The Role of Professional Status in Mediating the Gendered and Racialised Experiences of Nigerian Women Working in the NHS: An Interdisciplinary Approach

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Abstract

The 'feminisation' of international migration, reflects an increase in the health sector migration from African countries to the UK, particularly from countries with previous colonial relationships to the UK, such as Nigeria. However, the impact that the intersections of racialised, gendered and immigrant identity status have on identity and occupational opportunities for Nigerian women who migrate to the UK is under researched.

Addressing this gap, Interpretative Phenomenological Analysis (IPA) was performed on interviews with twenty-four Nigerian women, twelve doctors and twelve nurses working in the NHS. All participants were interviewed using unstructured interview, eight of whom were interviewed a second time using semi-structured interviews to further develop analysis.

IPA proved a fruitful method for in-depth analysis of the participants' experiences, and the findings captured three superordinate themes: 1) The process of becoming; 2) Inequalities at work; and 3) Coping with threatened identities. Four conceptual frameworks were applied in interconnected ways to further interpret the findings. These were: Acker's inequality regimes from organisational studies, Hall's conceptualisation of identity from cultural studies, an intersectionality lens from Black feminist scholarship, and Lazarus and Folkman's coping strategies for stress, from Psychology.

Overall, this study highlighted how those seeking higher status professions may experience greater stressors, due to intersections of racialised and gendered positionality. The thesis also showed the value of an interdisciplinary and intersectional approach; and contributed to developing knowledge of inequality regimes in the NHS; and increased analysis of Black migrant women's experiences in a context where their voices are often absent.

CHAPTER 1 INTRODUCTION

1.1 Overview

This thesis presents findings from a qualitative research study that was conducted with Black professional migrant women working in the NHS. It explores the gendered and racialised experiences of the participants and assesses the role that professional status played in mediating their gendered and racialised experiences.

This chapter delves into the researcher's personal interest in this study as well as offering some background information. It also provides definitions of terms commonly used throughout the thesis, and then describes the structure of the chapters.

1.2 Setting the Scene – Researcher's Background

Growing up as a girl child in Nigeria, I was always aware of the intricate game of politics of gender into which I was born. I had to learn how to navigate through the patriarchal terrain of Nigerian society. Throughout my childhood and early adulthood years in Nigeria, I was constantly aware of my being 'visibly othered' as female. I often had to engage in performative utterances and acts of femininity in a daily navigation of everyday sexism. The gendered socialisation process in Nigeria meant that roles, responsibilities, and expectations were gendered. Gendered identity in Nigerian culture is linked to value systems as well as issues of social, economic and political power, all of which consequently shape the daily experiences of girls and women in society.

Chimamanda Adichie (2014, p.13) aptly portrayed the value and perception of the girl child in Nigeria in a statement in her book 'We Should All Be Feminists'. She said, "Girls [Nigerian girls] are taught to shrink themselves, to make themselves smaller. We say to girls, you can have ambition, but not too much, you should aim to be successful, but not too successful, otherwise you would threaten the man. Nigerian girls but never Nigerian boys are socialised to aspire, not for jobs or other accomplishments, but to compete for the attention of men, and aspire to marriage". Adichie explains that this makes marriage the most significant life choice for females.

My awareness and experiences of sexism in Nigeria was one of several issues that sparked my passion for exploring gender issues. The harmful cultural gendered practice of early marriage altered my mother's career aspiration to train as a pharmacist and set her off on the journey of wifehood and motherhood, and she got side-tracked to study food and nutrition. My mother's personal gendered experiences also ignited a spark of interest in these issues for me. At the time, I thought my mum's experiences were purely gendered, but over the years, I have come to realise that her experiences were intersectional in nature, as her gendered and marital status intersected to structure her experiences, which in turn shaped my research interest. My mother's career trajectory, her life choices, and subsequently the outcome of her life were altered by the intersection of her gender, ethnicity and marital status.

Similarly, my migration to the UK in 2006 made me more aware of my entanglement in a completely different web of identity, and I adjusted to a different kind of 'visible othering', I was 'Black', an 'African' and an 'immigrant!'. I became aware of my acquisition of new identities; in the words of Stuart Hall (1997a; p.41), I emerged "a new global, a new subject of the politics of

identity and position", and was conscious and aware of being 'visibly othered' in a different context. I gradually adjusted being these new identities. Unlike in Nigeria, racist and sexist experiences are generally covert and subtle in the UK, although I did experience some overt discrimination, such as the time a group of young boys shouted 'Black witch' at me from across a street in Newcastle. Subtle or overt, being disadvantaged, doubly or triply disadvantaged can be mentally exhausting. Equally, some identities, possibly achieved work identities with high professional status may provide some important protection from disadvantage. Hence, the need to explore the role that an achieved identity and status such as one's professional status plays in mediating the gendered and racialised experiences of Nigerian women in the NHS.

1.3 Definition of terms

For the purposes of this study, certain terms will be defined to aid better understanding and give clarity to the reader.

A8: An acronym that represents the eight (8) countries that joined the European Union in 2004, apart from Malta and Cyprus

BME: This is the acronym for Black and Minority Ethnic people, though there are debates around the use of BME, rather than BAME, which stands for Black Asian and Minority Ethnic, which includes the Asians (Sandhu, 2018).

Black: In this study, the use of the term Black refers to Black African, Black Afro-Caribbean and Black African American people, as there are differing opinions regarding the descriptive terminology for non-white people (Farmer, 2013), or those who have origin in any of the Black ethnic groups of Africa. I capitalise the term 'Black' because it constitutes a cultural or ethnic group of people.

Britain: The country will also be referred to as Great Britain and the United Kingdom interchangeably in this study.

Global North: This represents the economically developed countries of Europe, North America, Australia, Israel, and South Africa, amongst others (Odeh, 2010).

Global South: This represents the economically developing countries of Africa, India, China, Brazil, and Mexico amongst others (Odeh, 2010).

Migrant: This term will be used interchangeably with the term immigrant. The terms 'migrant' and 'immigrant' used in this study include 'persons subject to immigration control', who need permission to enter and or remain in a country besides their country of birth, and those who are not subject to immigration control and who have a right of abode (unrestricted right to enter and live in the UK).

Migration: This is defined as the movement of people from one place to another. When this movement occurs across national boundaries, it is known as international migration. However, the process of leaving one's country of origin, the sending country, is known emigration, while entry into another country, the destination country, is known as immigration. These terms will be used accordingly throughout this study intermittently.

Destination country: This refers to the country of arrival for an immigrant away from their country of birth. The term will be used interchangeably with host country.

White: This is a descriptive term for light-skin people describing skin colour, rather than a group of people, and so does not constitute a cultural group of people, and will not be capitalised in this study. The term 'white' will be used interchangeably with Caucasian to refer to 'white' people, in part, because the participants used both terms.

1.4 Theoretical Background to the Study

The National Health Service (NHS) has been heavily reliant on migrant labour from overseas since its inception in the mid-20th century (Alexis & Vydelingum, 2004). Early 21st-century migration has been deeply affected by a migration of doctors and nurses from the Global South to the Global North (Healy & Oikelome, 2007; Kingma, 2007). This is a change from the Global North-North nurse migration, and Global South-South nurse migration patterns that existed previously (Kingma, 2007).

With the rising demand for skilled healthcare workers in the Global North, it is often assumed that the professional status of these highly skilled migrant workers protects them from exploitation and discrimination in the NHS (Anderson, 2010; Oikelome & Healy, 2013). However, this is not the case, as there are well documented reports of discrimination against Black and Ethnic Minority (BME) workers in the UK. There have been recent reports of 'entrenched racial inequality' experienced by BME workers in the NHS (British Broadcasting Corporation, 2016; Campbell, 2018a, 2018b), pointing to the importance of researching Black (especially Black women) immigrants' experiences of working in the NHS.

Migrants are reported to have differential labour market experiences based on factors such as race and gender (Dustmann & Weiss, 2007), age and education (Dustmann & Theodoropoulos, 2010), length of residence in the country and proficiency in the host country's language (Dustmann & Fabbri, 2003; Dustmann & Weiss, 2007), with a positive correlation between proficiency in the language of the host country, employment probability, and higher earnings

(Dustmann & Fabbri, 2003), as well as the formation of identity with home and host countries (Casey & Dustmann, 2010). Analysis of the UK 2011 census showed that there were differential labour market experiences and outcomes for different ethnic minorities in the UK. These differences were attributed to factors such as levels of education, ethnicity, geographic location, and religion (Catney and Sabater, 2015). The census data for 2011, for example, demonstrated that although Nigerian people had the second highest proportion of individuals with level 4 and above educational qualifications, and although these people had high proficiency in the English language, it took a greater number of years of residence in the UK to see a higher proportion of Nigerians in the highly skilled employment sectors. As such research shows, ethnicised and racialised identities, as well as country of qualification, shape career trajectories in the UK (Oikelome & Healy, 2005; Oikelome & Healy, 2007), so that race and ethnicity have been identified as significant categories of oppression and marginalisation which are thus worthy of further study. However, it is also important not to study categories of oppression separately. For example, there is significant evidence to suggest that the organisational experiences of Black women are different from Black men, or from white women. Black women are underrepresented in top management and high professional status positions (Bell & Nkomo, 2003). Therefore, there is a need to explore the experiences of Nigerian migrant women.

Recent findings highlight a culture of gender and racial discrimination in the NHS, with gender discrimination particularly taking place against female medics (Campbell, 2016; Davis, N. 2019; Hanley & Hussey, 2016), while racial discrimination in the NHS is experienced mainly by non-white ethnic minorities (Campbell, 2018a; Campbell, 2018b; Kyriakides, & Virdee, 2003). It has been reported that while Black male doctors in the NHS earn less than their white colleagues,

Black female doctors earn even less than Black male doctors (Campbell, 2018a). This is also the case for Black female nurses and midwives, who earn less than Black male nurses and midwives, who also earn less than their white colleagues. This is also applicable to all Black NHS workers (Campbell, 2018a).

Research has thus shown the double disadvantage of female BME staff working in the NHS, an equal-opportunities employer. These findings highlight the importance of further qualitative research into the processes and procedures that create and maintain gender and racial inequality against Nigerian migrant women working in the NHS.

To gain better understanding of the complexity inherent in the study of multidimensionality with reference to identity categories, this research took an interdisciplinary approach. From an organisational studies perspective, Acker's (2006) inequality regimes framework was adopted to explore Black Nigerian women's experiences of working in the NHS as well as to investigate the processes and procedures that produced and reproduced inequalities in spite of the equality and diversity policies in place in the NHS. Furthermore, Acker's conceptual framework (2006) was used to explore the ways in which professional status mediated these experiences, within an organisational context. This study also drew on Hall's (1990, 1996a 1996b, 1996c, 1997a, 1997b) cultural studies approach to identity to map out how participants' historical identities interacted (known as intersectionality) to shape their new identities and positionality. In addition, Lazarus and Folkman's (1984) psychological theory on coping with stress was used to conceptualise how participants responded to the challenges they encountered as a result of multiple identities interacting and intersecting within a world experienced as racist and sexist.

This interdisciplinary approach to the study of an under-researched group of women offers an original contribution to scant research, gives a voice to these women that is rarely heard, and contributes to research in migration and feminist organisational studies by introducing professional status as a novel category in an intersectionality-informed study.

1.5 Structure of the Thesis

This thesis is organised across eight chapters. Below is a summary of the subsequent seven chapters following this introductory chapter.

- Chapter Two: This chapter provides a review of literature on migration, particularly international healthcare migration from Global South to Global North countries. It further examines theories of international migration, both from an economic and gendered perspective. The gendered perspective will aid the understanding of experiences of migrants from the Global South and their differential migration outcomes. The pattern of migration and experiences of migrants from Global North to North will be compared with the pattern of migration and migrant experiences from Global South to North countries, to ascertain the role that race and ethnicity play in migration outcomes. The pattern of migration from Nigeria to the UK will also be examined, and patterns which are located within a global market and movement of health workers will be critically analysed from a gendered and racialised approach. This chapter also reviews literature that looks at ways in which gendered and racialised identities structure the experiences of Nigerian migrants the UK (Healy & Oikelome, 2007). This chapter will be concluded by looking at literature on the ways in which professional status impacts on the status of immigrants.

- Chapter Three: This chapter discusses the theoretical frame that guides my work. It looks at the theoretical framing of identities from a cultural studies approach, using the work of Stuart Hall as a lens that conceptualises identity as multiple, fractured and fragmented. Hall (1990, 1996a, 1996b,1996c,1997a, 1997b, 1997c) looks at the fluidity and shifting of identity as it is transformed in social processes such as globalisation, migration, intersectionality, inequalities at work, and coping. In order to understand the social identity and identification as a process, this chapter looks at the conceptualisation, construction and positionality of the different social identities, migrant, racialised, gendered and ethnicised identities. This chapter also draws on Acker's (1990, 2006) concept of inequality regimes and looks at the NHS as an important space for the production and reproduction of inequalities through its interrelated processes and practices. Furthermore, this chapter considers the ways migrant workers psychologically cope with their status as 'other', and what coping strategies they employed in the process.
- Chapter Four: In this chapter, the methodological approach employed in this research is discussed, providing justification for my choice of research design and methods. This study was considered from a qualitative research approach, using an intersectionality lens and drawing from a Black feminist perspective. This chapter discusses the method section and includes information on the design of the research, research procedure, the sample composition and size. I then outline the research process of data collection and analysis, my position as a researcher and problems encountered, and ethics consideration made.
- Chapters Five: This chapter introduces the first superordinate theme the '*process of becoming*. It describes the identity shifts, transformations and representations

engendered by the process of migration and its associated demands in understanding and representing oneself differently, particularly in relation to others in society. This chapter focuses on the narrative of the different identities and positionalities which emanates from their experiences of what they have become in the process of migration; Nigerian women in the UK, Nigerian migrants, and Black. This superordinate theme thus directs attention to exploring the emerging identities at play in the process of migration. This chapter commences with the findings and analysis and the discussion form the later part of the chapter.

- Chapter Six: This chapter focuses on the second superordinate theme across the data set, '*inequalities at work'*, and this relates to participants' experiences of being 'othered' and disadvantaged on the grounds of their ascribed race/ethnicity, gender, and their immigrant status, as well as how these then structured their experiences at work. This chapter unveils the participants experience of inequalities produced through their positioning in relation to their gendered, racialised and ethnic ascribed identities. This chapter also presents the multiple positions of marginality in which the participants found themselves, as well as the practices and processes that produced such inequalities at work. Again, this chapter starts off with the analysis of the superordinate theme and then a discussion on the findings. This chapter now focuses on their experiences as they established their careers in the NHS.
- Chapter Seven: This chapter introduces the superordinate theme '*coping with threatened identities*'. This chapter focuses on the stressful and challenging experiences that emanated from the participants' multiple positions of marginality at work and at home. Most of the experiences at home and work were identity-threatening, as they often

encountered negative stereotypes associated with participants' racialised, gendered, and immigrant identities in ways that were stressful, challenging, and in some cases potentially harmful. These experiences created significant stresses in the lives of participants, which were particularly experienced around employability, daily interactions at work, career progression, and domestic activities at home. It focuses on exploring the strategies as well as the problem-based and emotion-based resources that the participants deployed to cope with the experiences which they found threatening to their identities, particularly in terms of coping with the demands of their new identities and responding to the discriminations and challenges experienced in the labour market.

- Chapter Eight: I draw together the findings of chapter five, six and seven, aligning them to the research questions and the theoretical frameworks used, and highlighting the empirical contributions of my research.

CHAPTER 2 LITERATURE REVIEW

2.1 Overview

This chapter provides a systematic and critical review of literature on healthcare migration from the Global South to the UK. It also offers several theoretical approaches to international healthcare migration, from an economic and a gendered perspective. The chapter also addresses the pattern of migration from Nigeria to the UK, particularly gendered migration, locating these patterns within the healthcare sector, and highlighting the role and experiences of women in migration.

The chapter then provides a review of existing literature on the ways in which racialised and gendered identities structure the experiences of Nigerian migrants to the UK, including research that explores race and gender separately and how these identity categories intersection with each other. The chapter concludes by introducing a novel aspect to intersectional work, highlighting the role of professional status. In so doing, this chapter sets the scene for the thesis and its focus on the examination of multiple intersections of social categories, including professional status, for understanding Nigerian women's experiences of working in the NHS.

2.2 Systematic Search for Literature

Through concept mapping, a systematic search for literature was conducted, and the most relevant studies that provide answers to the research questions were retrieved and assessed. The research questions were broken down into separate areas to identify key words and terms. These

included profession, professional status, gender, experiences, race, racialised experiences, identities, Nigerian migrants, Nigerian doctors, Nigerian nurses, NHS, migration, international migration, gendered migration, and migrants. PsycARTICLES and PsycINFO were used to locate scholarly research findings in psychology using some of the keywords above, while other multidisciplinary databases used include EBSCO, JSTOR, Web of Science, Google Scholar, Springerlink, and Social Science Research Network (SSRN). Furthermore, search engines, libraries, websites and grey literature were used to locate relevant literature. A Boolean search was then conducted, combining key words and synonyms of keywords, as follows: Nigerian 'AND' migrants 'OR' immigrants 'AND' 'experience', refined by date (1990-2016). A Boolean search combining the keywords professional 'AND' status 'AND' migrant 'OR' immigrant 'AND' experience revealed this to be an underdeveloped research area, thus making this study a novel contribution as a result of its focus on migrant experiences from a professional status perspective. Following electronic searches, a snowballing technique was also used within article to follow up references in the reference lists and bibliographies of other articles.

2.3 Understanding International Migration

Migration is of course not new; people have always been on the move. However, international migration, the movement of people across national borders and boundaries, is a new and global phenomenon. What is increasingly alarming is that about 3.4% of the world's population are international migrants in 2017, a sizeable increase from 2.8% in 2000 as international migrants (United Nations, 2017). International migration is growing in scope, impact, and complexity. International migration is the priority of many governments and is at the forefront of many discourses due to its inherent complexity and changing patterns. One of the changing trends in

international migration is that countries which previously sent migrants are now receiving them, such as Spain and Italy (Arango, 2000). The pattern has also changed from Global South-South, or Global North-North migration to Global South-North (Kingma, 2007). What is particularly interesting about this trend amongst the different waves of immigration that have occurred in the past is that it is a movement of people from low-income to high-income countries, signifying that immigration is economically motivated. Trends in international migration revealed that high-income countries hosted nearly 165 million people (64%) of the total number of international migrants worldwide in 2017, 48% of whom were women (United Nations, 2017). While the United States hosted the largest number of international migrants in 2017, the United Kingdom was the fourth largest immigrant-receiving country in that year (United Nations, 2017).

2.3.1 International Migration into the UK

The UK population has grown tremendously since the start of the 21st century, which is the result of economic and political factors and relationships. For example, there was a mass migration of European people into the UK in 2004, particularly from the A8 countries after the accession when eight countries joined the European Union (Anderson & Rogaly, 2005; Blanchflower, Saleheen, & Shadforth, 2007). The income gap between the A8 countries and the UK suggests that this migration was motivated by economic and political factors (Vargas-Silva, 2014). Economic and political factors are key motivators for migration into the UK, both today and historically. For example, there was migration in the 17th and 18th century linked to the British Empire that resulted in a substantial proportion of immigrants arriving in the UK (Castles, 2000; Fedorowich & Thompson, 2013; Harper & Constantine, 2010). Similarly, the 20th Century witnessed Commonwealth migrants from the Caribbean countries and displaced

homeless European workers from the Caribbean, often known as the Windrush Generation (McDowell, 2009) who were invited to the UK between 1948 and 1971 for the purpose of nation-rebuilding after the 2nd World War. While, a different set of Commonwealth migrants moved to the UK, after the 1971 Immigration Act stemmed immigration from the Caribbean countries, from South Asia, India and Pakistan (Berkeley, Khan, & Ambikaipaker, 2006). Early 21st century migrants to the UK are mainly from the Global South, and are also believed to have migrated for economic reasons (Kingma, 2007). Current levels of immigration have led to government policies that implemented the use of immigration controls to act as a filter, sifting the 'desirables' and the 'undesirables'. (Anderson, 2010). In reporting the incidences of migration in this order, it highlights the observation of significant trends in migration during these periods in history.

Moving countries to earn more money is thus a key motivation for migration. As a result of the geographical wage differentials between the countries involved in international migration, it has been argued that many of the international migrant population worldwide are economic migrants (Bach, 2007; Borjas, 1989), particularly those engaging in the Global South-North migration pattern. Therefore, many theories focus on the economics of immigration. While many contemporary theories have taken an economic approach to explain the initiation and perpetuation of international migration, it has been argued that it is critically important to incorporate gender into theories of international migration (Boyd & Grieco, 2003; Kofman, 2000, 2004, 2005; Kofman, Phizacklea, & Raghuram, 2000). Equally important is the need to take an interdisciplinary approach to migration since the "experience of migration embraces every dimension of human existence" (Castles, 2007, p. 353).

2.3.2 Theories of International Migration

Various theoretical approaches have considered the initiation of migration. *Neoclassical theory* (Jennissen, 2007) was developed to describe and explain a range of push and pull factors driving emigration and immigration, such as wage differentials between the origin and destination countries (Bach, 2007). The neoclassical theorists focus on the geographic differences in the demand and supply of labour as well as the resulting effect on differentials in wages between the origin and destination countries, all in a bid to maximise their wellbeing (Bach, 2007; Massey et al, 1993). The countries with a shortage of labour in relation to its capital consequently have high wages and vice versa, hence the movement of immigrants from countries with high labour supply and low wages to countries with labour shortage and high wages (Borjas, 1989; Massey, Arango, Hugo, Kouaouci, & Pellegrino, 1998). The neoclassical theory has been utilised to explain the international migration of highly-skilled healthcare workers, predominantly nurses and doctors (Buchan et al, 2003; Healy & Oikelome, 2007; Kline, 2003; Vuijicic et al, 2004).

The UK has attracted international migration through its active recruitment of workers from overseas to fill its shortage of healthcare workers (Buchan, 2002; Healy & Oikehome, 2007). Other pull factors to the UK have been identified, such as career development opportunities, good remuneration, and quality education, as well as opportunities for educational training and good remuneration (Healy & Oikehome, 2007). In the case of the Global South, particularly Nigeria, push factors identified include the deteriorating socio-economic conditions, political unrest, deepening poverty and deteriorating living and working conditions, as well as wage freezes. These factors have led to the emigration of a huge number of highly-skilled healthcare workers to the UK (Adepoju, 2005). Consequently, from the pattern of international immigration

assessed, immigrants who are migrating from the Global South to the Global North do so not only to meet the demand of a labour shortage but also to meet personal survival demands. Therefore, according to this theory, the decision to migrate stems from a combination of pull and push factors as well as the wage differential outcomes of the labour demand and supply dynamics.

A different theory known as the *new economics of labour migration approach* criticised neoclassical theory for not taking into consideration other possible social actors and entities such as household and families. and their influence on the decision to emigrate (Borjas, 1989; Castles, 2004). This theory posits that migrant behaviour and decision-making involve the entire household and/or family rather than just the isolated individual (Bach, 2007; Jennissen, 2007). Stark (1984) claims that this approach is a resource maximisation strategy whereby household economic activities are diversified, meaning that while some family members go to the local labour market, others go to international labour markets. This is done to maximise family income while minimising risk to the family's economic wellbeing (Massey et al, 1993; Massey, 1999).

The *dual labour market theory* takes a completely divergent view on the triggers for international migration (Massey, 1999). While the neoclassical and new economic theories focus on micro-level analysis of decision models, the dual labour market theory argues that international migration is motivated by the labour demands of modern industrial economies (Massey et al, 1993). Piore (1979) argues that immigration stems from the constant demand for migrant labour for jobs refused by the indigenous workers. This theory analyses international migration from a

macro level and sees that national governments regulate the numbers and characteristics of the immigrants through immigration policies.

The *migration network theory* posits that international migration occurs between the micro and the macro level, meaning that the decision-making process is individualistic in nature, yet is a response to structural differences between countries or regions (Faist, 1997). This pattern of migration is seen as a form of social capital in which social networks are central, and in which migrants move to countries where they have the necessary connections to settle easily into the labour market, at little or no cost, and access higher wages (Arango, 2000). All these theories of international migration involve push and/or pull factors and suggest that migration decision-making, whether at the micro, macro or meso level, influences migration behaviour, hence the need to ascertain the pattern of migration from Nigeria to the UK.

2.3.3 Nigerian Immigrants in the UK

The UK is not a new destination for Nigerian people. For example, Olaudah Equiano, a transatlantic slave, was the first documented person to travel between Nigeria and the UK in the 18th century (BBC, 2005; Okpewho, 2009). The UK increasingly became a key destination for Nigerian immigrants, particularly after Nigeria gained its independence from the UK in 1960 (BBC, 2005; Hernandez-Coss & Bun, 2007; Van Hear, Pieke, & Vertovec, 2004). Those emigrating to the UK conveyed a sense of optimism as they hoped for the better pay, better career opportunities and training in the UK when compared to the deteriorating economic and political conditions they experienced in Nigeria (Akinrinade & Ogen, 2011; De Haas, 2006;

Hagopian, et al, 2004). Due to the historical colonial relationship between Nigeria and the UK, the latter had a particularly strong pull for these and subsequent Nigerian migrants, which was also strengthened by that fact that one of official/political languages of Nigeria is English (BBC, 2005; Fawcett, 1989; Spaan & Van Moppes, 2006).

A study of the pattern of emigration from Nigeria to the UK in the late 20th and early 21st centuries revealed that most of these immigrants were skilled workers, students, asylum seekers, and refugees (Adepoju, 2000; BBC, 2005; De Haas, 2006; Mberu & Pongou, 2010). Most of these skilled migrants were healthcare workers, including doctors, nurses and other healthcare personnel (Adepoju, 2000; De Haas, 2006).

The major oil crisis of the late 20th century in Nigeria, which is both oil-rich and oil-dependent, marked an increasing trend in the Nigeria to UK migration route (Bakewell, De Haas, Castles, Vezzoli, & Jónsson, 2009). Political unrest and economic decline in Nigeria appeared to drive Nigerian people to migrate in masses, making international migration to the UK a survival strategy and coping mechanism for pursuing economic mobility and securing family survival (Adepoju, 2004).

However, there has been a debate on the drivers of international migration, particularly in terms of movement from Global South to Global North countries. In these debates, the drivers of contemporary trends in international immigration have been a topic of debate in general, and their categorisation has particularly been disputed (Astor et al., 2005), an issue that will be

discussed in more detail in chapter three. What is important to note for now is that there are a variety of economic, social, and political drivers of international immigration from Nigeria to the UK (Bakewell et al., 2009). The Annual Population Survey 2012-2013 (Cooper, Campbell, Patel, & Simmons, 2014), for example, categorised Nigerian immigration as 14% economic, 30% study, 20% family, and 17% dependants, while others have suggested that Nigerian people migrate to the UK primarily for employment opportunities and higher education purposes (De Haas, 2006; Hernandez-Coss & Bun, 2007).

A significant shift in UK government policy also had an important impact on Nigerian immigration to the UK. The Highly Skilled Migrant Program (HSMP), implemented between 2002 and 2008, led to an increase in economic migrants. Many Nigerian immigrants entered the UK via the highly skilled route (Astor et al., 2005; De Haas, 2006, Healy & Oikelome, 2007). Most of the literature on the highly skilled migration route from Nigeria to the UK focuses on health care migration; there is a scarcity of research on other highly skilled Nigerian immigrants.

Research on health care migration shows both push and pull factors in migration. As well as the economic decline in Nigeria being a push factor that encouraged emigration to the UK (Adepoju, 2004; De Haas, 2006; Hernandez-Coss & Bun, 2007). An illustration of the reciprocal relation between the UK and the Nigerian healthcare workers was demonstrated when 1,510 UK work permits were issued to Nigerian health and medical personnel in 2003 (Eastwood et al, 2005), while 432 Nigerian nurses were registered in the NHS in 2002 (Ross, Polsky, & Sochalski, 2005). Nigerian and South African doctors represent more than 85% of overseas-trained doctors

from Africa in the NHS, making them the largest faction within this group (Connell, 2010; Connell, Zurn, Stilwell, Awases & Braichet, 2007). There are other groups apart from highly skilled healthcare workers migrating in relatively large numbers from Nigeria to the UK, they include the student group and the marriage/family-related group.

The Nigerian student population in the UK is an equally important category of Nigerian emigrating to the UK, since the deteriorating state of the Nigerian educational system 'pushed' many to seek quality higher education in Britain (Aboderin, 2007; De Haas, 2006; Hagopian et al., 2005). Nigerian students have been 'pulled' through active recruitment by countless immigration 'consultants' from UK universities (De Haas, 2006). Interestingly, Nigerian people are academic qualification-oriented, due to the intrinsic value of an academic qualification in the labour market, and consequently, academia's potential to improve their socio-economic status. This results in migration in pursuit of better education in the UK (Aboderin, 2007; Banjo, 2012).

There are also marriage and family-related migrations from Nigeria to the UK (Coleman, 2004). Nigerian women's historical and contemporary immigration was tied to their partners, since Nigerian wives moved to join their husbands in the geographic location in which he was situated (Watts, 1983). Recently, it has been claimed that professional Nigerian women are now emigrating and leaving their husbands with the children (Adepoju, 2005), but there is no statistical data to support this observation. This may be because there are so few women immigrating autonomously or because of the way international migration research on spousal or

marriage-related migration tends to focus on the wives, making the migration of male dependents invisible (Charsley, Benson & Van Hear, 2012).

Theorists have acknowledged feminisation as being a core dimension of contemporary international migration, including migration from Nigeria (Akinrinade & Ogen, 2011; Donato, Gabaccia, Holdaway, Manalansan, & Pessar, 2006; Kofman, 1999). Nonetheless, the numbers of the women migrants as well as the capacity and social position in which these migrants move is mostly undocumented (Aboderin, 2007). Understanding gender is critical in migration, particularly international migration, as it will provide information on gender-specific migration, labour market experiences at destination, and the outcome for women migrants (Boyd & Grieco, 2003). Furthermore, Boyd and Grieco (2003) explain that a focus on gender in migration will also clarify why there is a concentration of women migrants in certain occupations and not others.

2.3.4 Healthcare Sector Migration

International migration of highly skilled workers has been in existence from the late 20th century (Lowell & Findlay, 2001; Mahroum, 2000, 2001; Millar & Salt, 2007; Regets, 2007). However, global healthcare migration has gained public attention more recently because of concerns that it represented a significant 'brain drain' (Connell, 2008, 2010). Global healthcare migration became a major concern as it represented the emigration of skilled migrants responding to forces of push and pull from economically poor to richer countries, and so left those migrants' home countries with fewer healthcare workers.

The first phase of the international migration of skilled health workers started with the movement of missionaries from Western countries to colonies, due to the poor healthcare system available at the time in the colonies, and the high mortality rate of those countries (Connell, 2009, 2010). International migration has since undergone a variety of transformations in the trend and pattern of migration; from regional in the mid-20th century, to a globalised move of healthcare workers to fill local shortages in healthcare in other countries.

The regional pattern observed in international health care migration in the 1960s and 1970s became a Global North-North (e.g. Irish workers in Britain) or Global South-South migration (e.g. South African nurses in the Seychelles) of healthcare workers (Kingma, 2006), marking the second phase of the international healthcare migration (Connell, 2009). However, this pattern shifted to a Global South-North trend of healthcare workers in the early 21st century (Kingma, 2006). While there was a global need for skilled healthcare workers, the migration of skilled workers from economically poor to economically rich countries (known as the brain drain) raised concerns about ethical considerations in international migration (Dodani & LaPorte, 2005; Kingma, 2006; Stilwell et al., 2004).

The World Health Organisation (WHO) estimated a global shortage of 7.3 million healthcare professionals in 2013, and an impending increase to 12.9 million by 2035 if this shortage is not addressed. The WHO further stated that this shortage could have serious health implications for billions of people around the world. This estimate reveals the magnitude of the global healthcare crisis (Aluttis, Bishaw & Frank, 2014) and also shows how this demand-driven nature of

healthcare has led to migration, linking the Global North and South in a global healthcare chain (Connell, 2008). While the shortage of healthcare workers is not universal according to WHO (2006), most of the world's countries are entangled in the complexity which health care migration represents (Connell 2008). WHO (2006) announced a shortage of skilled healthcare workers in 57 countries, including a lack of doctors, nurses, and midwives, as well as other non-frontline healthcare personnel. This shortage of healthcare workers is the result of several demographic, economic, social, health, cultural, and political factors (Connell, 2008; Kingma, 2006). Examples of these factors include an aging population and workforce as well as increasing healthcare expectations in the host countries, the rise of HIV/AIDS, and desires for better working conditions of healthcare workers (Connell, 2008, 2010). Interestingly, countries previously known as source countries are increasingly becoming destination countries or both source and destination countries. The UK is one such countries, as it is now both a source and destination country, attracting healthcare workers while British trained healthcare workers themselves are emigrating (Connell, 2008, 2009, 2010). Global healthcare migration has attracted much attention in the early 21st century, and although many countries face the general challenge of meeting the health care needs of its people, the scenario is different for individual countries (Kingma, 2001), meaning that UK healthcare migration needs to be considered specifically.

There has been a change in the trend and pattern of the migration into the UK over the years. Since its inception in 1948, the UK's NHS has a long history of recruiting overseas skilled healthcare workers to meet its skills shortages (Batnitzky & McDowell, 2011; Likupe, 2006). The UK has experienced a fluctuation of shortages and surpluses, although more shortages, and

so has had to rely on other countries to meet its health needs (Anderson & Ruhs, 2010; Martin, 2010). For example, in the mid-20th century, the UK was a destination country to Irish doctors (Gish, 1972 cited in Connell, 2008), with three quarters of all medical graduates from Ireland emigrating to the UK. At the start of the 21st century, the UK had shortages of doctors (Young, Noble, Hann & Sibbald, 2003) and nurses (Aikan et al., 2004; Kline, 2003), but at the current time, new nationalities, particularly from outside of the EU, make up important sender countries.

The UK has therefore benefited from the voluntary migration of healthcare workers from overseas, since international recruitment and migration have always been characteristics of global health systems (Dovlo & Buchan, 2004). The migration of health care professionals is not only primarily demand-led, as suggested by Stilwell et al (2004), but is also driven by a lack of training and research and professional development opportunities (Aboderin, 2007; Kingma, 2001), deteriorating living and working conditions (Adepoju, 2005; Kline, 2003), and poor remuneration rates (Kline, 2003) in the sending countries.

The UK is currently in a paradoxical position, as it has been listed as both a primary donor country and a receiving country of nurse migration, losing and yet receiving skilled nursing personnel (Kline, 2003). International nursing migration has reversed previous standard migration structures in which women migrated as family migrants or dependants (Connell, 2010). Healthcare professions such as nursing are considered ‘a portable profession’ (Kingma, 2006) and medicine a ‘passport to prosperity’ (Connell, 2008). This is due to its provision of migration opportunities both for those moving to and leaving the UK.

The healthcare skills shortages situation in the UK has been propelled by demographic pressures, economic conditions, and political factors (Brown, 2006) including work-related stress, deteriorating working conditions, overworking yet being underpaid, an aging workforce, a greater range of jobs for women outside nursing, and low morale (Connell, 2008; Kingma, 2001). The aging population factor and its attendant increasing healthcare demands has sparked debates amongst scholars (Payne, Laporte, Deber & Coyte, 2007; Spijker & MacInnes, 2013) and fears amongst policy makers, particularly as the NHS is now heavily dependent on overseas health workers, often from other EU countries, India, the Philippines, South Asia, and Africa to meet its healthcare needs (Aikan, Buchan, Sochalski, Nichols, & Powell, 2004; Bloor et al., 2003; Kangasniemi, Winters & Commander, 2004; Siddique, 2014).

While there seems to have been a change in the trend of nurses leaving the profession, most of those who left in April/May 2017 were in the age range of 21-30, leading to a shortage of 40,000 nurses and 3,500 midwives in England alone (Siddique, 2017). The increasing NHS staff shortage has raised concerns, as 34,941 UK nurses and midwives left the register in 2016/2017, meaning that 20% more nurses and midwives left than joined the profession. Many leavers cited workplace pressure as well as poor pay and benefits as reasons for leaving (Siddique, 2017). These statistics point to a need to recruit more overseas nurses; however, government policy has attempted to reduce this recruitment. For example, the development of a code of practice by the Department of Health sought to address the ethical concerns of active recruitment from economically developing countries to developed countries (Buchan & Dovlo, 2004). Despite this code of practice, healthcare migration has continued, and as recently as March 2016, the

recruitment of migrant nurses as a strategy for meeting NHS staff shortages has been to focus on recruiting non-EEA nurses due to their lower costs (Migratory Advisory Committee (MAC), 2016). The UK thus engages in active recruitment of overseas health workers to meet its needs, as home-trained healthcare workers could not sufficiently meet its present healthcare demands (Batnitzky & McDowell, 2011; Buchan & Dovlo, 2004; Young, Noble, Hann, & Sibbald, 2003), a recruitment strategy that is facilitated by the voluntary migration of health workers into the UK (Young, Noble, Hann, & Sibbald, 2003).

The focus on addressing the shortage of nurses in the UK has also changed the gendered patterns in health workers' migration. In the 1960s, the demand was for skilled medical professionals, a majority of whom were male; now, there is a greater demand for nurses, a traditionally female job, making females the main migrant group of health workers (Connell, 2010). The impact on these migrants, both men and women, as they take up work in the UK is discussed in the following section.

2.4 Racialised Experiences of Migration

Migration is a complex process. It is a border-crossing process that can potentially alter the identities of migrants as a result of social, economic, cultural, and political implications (La Barbera, 2014; Newman, 2006). The changing role of borders from state to international borders has triggered the rise of identity politics, since borders no longer act as barriers to the movement of goods, services, and people, but have instead activated a new politics of space and place (Newman, 2006; Wilson & Donnan, 1998).

Identity categories are therefore central to the experience of migration, as identity gets transformed, re(constructed), and negotiated during migration processes (La Barbera, 2014). The media recently focused on the story of Dr al-Zuebi, a Syrian cosmetic surgeon who migrated from war-torn Syria to the UK in 2016. Having earned £6,000 a month in Syria, Dr al-Zuebi was barred from working in the UK because of his asylum status (Jamieson, 2016). His case exemplifies identity shift as an occurrence of the identification and categorisation processes that influence immigrants' experiences. Bordering made Dr al-Zuebi's professional status invisible, and consequently his socio-economic status, meaning that his trajectory as an asylum seeker in the UK is and will continually shape his experience. It is therefore apparent that one's immigration category – economic migrant, asylum seeker, refugee, student - can significantly define the boundary of the social and economic space in which people can operate as well as the legality of their employment (Ruhs & Anderson, 2010). A migrant's category of migration matters therefore, shaped as it is by immigration policies adopted to serve the needs of the UK economy (Nunn & Price, 2005). This points to the rationale for not looking at class in this thesis, since class may not be relevant for migrants - how do you categorise the class of someone who goes from 'being' a surgeon, to 'becoming' someone unable to work? This shift illustrates the way in which the whole class system becomes status unsettled by migration. The section below on professional status further explains the rationale for exploring professional status and not class in this thesis.

Dustmann and Weiss (2007) describe the ways in which immigration policies distinguish between high-skilled, intermediate, and low-skilled migrants. Highly skilled migrants are

considered the ‘best and brightest’, the ‘wanted’ and the ‘deserving’ category of migrants based on their economic value to the system (Carling 2007, 2011; Geddes, 2003), leading to the fierce competition of highly skilled workers within and between the economically developed Global South countries (Mahroum, 2000, 2001). Health workers are normally considered a high skilled cluster, supported by the Home Office labour market survey (2005), which showed that work permits issued to Nigerian people were clustered and concentrated in the health and care professional occupations (Salt & Millar, 2006).

In Global North countries, policies are constantly developed and redeveloped to tap into the emerging global market of highly skilled human resources, such as the ‘scientific visa’ for scientists in France or the ‘green card’ for IT professionals in Germany (Hooper, 2001; Mahroum, 2001; Shachar, 2006). The UK’s HSMP, placed emphasis on educational qualification and work experience, while basing its assessment of the applicant on their past earnings and achievements (Shachar, 2006).

The status of the skills categorisation of the migrant and current immigration policies thus impact on how successful an applicant is in being allowed to work in the UK (Catney & Sabater, 2015). Once in the UK, migrants have differential labour market experiences based on factors such as race and gender (Dustmann & Weiss, 2007), age and education (Dustmann & Theodoropoulos, 2010), length of residence in the country and proficiency in the host country’s language (Dustmann & Fabbri, 2003; Dustmann & Weiss, 2007). There is a positive correlation between proficiency in the language of the host country, employment probability, and higher earnings (Dustmann & Fabbri, 2003), as well as between the formation of identity with home and host

countries (Casey & Dustmann, 2010). Catney and Sabater's (2015) analysis of the 2011 UK Census also showed that there were differential labour market experiences and outcomes for different ethnic minorities in the UK and across different generations of immigrants in comparison with their native counterparts. Levels of education, ethnicity, geographic location, proficiency in language and religion all attributed to the disparities in labour market outcomes between first- and second-generation immigrants and their native counterparts (Dustmann & Theodoropoulos, 2010; Heath, Rothon, & Kilpi, 2008). Regardless of this variation, overall, first-generation ethnic minority immigrants, except for ethnically white immigrants, earn less in the UK than their British-born counterparts (Algan, Dustmann, Glitz, & Manning, 2010).

Research specifically on health worker migrants shows other patterns of discrimination. For example, studies focusing on the experience of registered nurses note complaints of diminished professional and social status in the UK (Aboderin, 2007), and that migrants in the sector reported feeling undervalued, de-skilled and underpaid (Matiti & Taylor, 2005). In addition, migrant nurses noted pressure to perform unqualified work in independent nursing homes (Aboderin, 2007; Hardill & Macdonald, 2000; RCN, 2003).

Doctors have also reported discrimination. For example, Oikelome and Healy's (2007) comparison of overseas-trained and UK-trained doctors revealed discriminative career structures that disproportionately disadvantaged the overseas-trained doctors. In comparison to UK-trained doctors, overseas-trained doctors described working longer hours, having higher workloads, experiencing a lack of transparency of appointment processes, receiving disproportionate referral rates, and having less autonomy in their work (Oikelome & Healy, 2007). Similarly, in another

study, Oikelome and Healy (2005) found that Nigerian doctors experienced a lack of recognition of their skills, experience and hard work. Therefore, while Nigerian immigrant doctors in the UK got a better remuneration package and better working conditions than they would have done working in Nigeria, overall they had low morale as a result of working in the UK.

In the context of this discrimination, one of the remarkable statistics identified in the UK 2011 Census was that the Black African ethnic minority group had the largest improvement in economic well-being between 2001 and 2011. This shift was attributed to the increased level of education amongst ethnic minority groups (Clark & Drinkwater, 2007). Other positive indicators include the ways in which the earning disadvantage of ethnic minority migrants improves with time spent in the UK (Algan et al., 2010; Chiswick, 1980). However, despite these positive indicators, as the research discussed above has shown, ethnicity and racialised identities, as well as country of qualification, shape career trajectories in the UK (Oikelome & Healy, 2005; Oikelome & Healy, 2007), so that race and ethnicity have been identified as significant categories of oppression and marginalisation.

2.5 Gendered Experiences of Migration and the Intersections of Gendered and Racialised Identities

Gender is also a category associated with oppression and marginalisation (Wojczewski et al., 2015). This is despite significant social changes that have led to an increase in women's autonomy and economic participation, as well as emerging opportunities for women (Boyd & Grieco, 2003; Hardill & Macdonald, 2000; Iredale, 2001). An increase in women's participation in education has given women increased access to the national and international labour market

(Adepoju, 2008; Boyd & Grieco, 2003; Brah, 1993; Docquier, Lowell & Marfouk, 2009). This shift ties into the changes in health worker migration outlined in earlier sections, which created a 'feminisation' of international migration through a turn towards recruitment of nurses, a job traditionally done by women (Adepoju, 2005, 2008; Connell, 2008, 2010). This feminisation of economic migration brought women to the fore where international migration is seen as a family survival strategy (Adepoju, 2005; Raghuram, 2004; Sassen, 2000; Sweetman, 1998) which has increased the numbers of women traveling independently for work (Brettell, 2000; Docquier, Lowell & Marfouk, 2009; Parrenas, 2000), including Nigerian women involved in international migration (Adepoju, 2000). However, whether travelling autonomously or as dependant wives, daughters, or mothers, migrant women's economic participation has increased in the UK (Castles & Miller, 1998; Raghuram; 2008). This is evidenced by the number of working-age migrant women registering for national insurance (NI) numbers, which increased by around 49% between 1996 and 2001 (Robinson, 2002). However, migrant women are concentrated in the secondary segment of the labour market in which work is flexible but there is no career progression due to its precarious nature (Schrover, Van der Leun, & Quispel, 2007).

Despite issues of precarity, an outcome of economic participation for migrant women is that they usually gain a new sense of control over key aspects of their lives (Brettell, 2000). As Brettell (2000) and others argue (e.g. Kofman, 1999; Morokvasic, 1991), this new sense of control is related to their participation in the labour market, since wage earning enhances their socio-economic status and power in the public and private spheres, provides increased levels of financial independence, and increases the likelihood of a more flexible division of labour in the

home, including shared parental responsibility. The experience of less sex segregation at home can also lead to improved domestic social relations (Wojczewski et al., 2015).

However, this socio-economic advancement requires migrant women to observe more egalitarian gender relations in the home, the classroom, and their workplace than they are used to, and this can cause subtle but gruelling stresses (Dimitrov, 2004). Dimitrov (2004) argues that stresses occur, because when immigrant women grow up in countries structured by gender differentiated spaces, with men and women dominating separate realms of influence, a move to engaging in gender-neutral relationships in the public and private spheres may be interpreted as going beyond the realm of womanhood. Thus socio-economic advancement can come with a psychological loss of valued identity. A range of other social, economic and organisational factors also limit the possibilities afforded to women through their participation in paid work. For example, the feminisation of the workforce structures women into particular jobs (such as those associated with teaching and nursing) which are often considered lower status than those predominantly done by men (Bolton & Muzio, 2008; Muzio & Tomlinson, 2012).

Understanding such structural disadvantages is increased when considering the intersections of ethnicity and gender. While ethnic minority immigrants are disadvantaged in comparison to their white immigrants and white British counterparts (Dustmann & Fabbri, 2003), the experiences of the visible minority migrants are further implicated and disadvantaged by gender (Dustmann, Fabbri, Preston & Wadsworth, 2003). The public sector in the UK labour market has been identified as highly reliant on the services of female migrant workers, both professional and low-skilled work. However, Caribbean, Pakistani, and Bangladeshi women are the most

disadvantaged in the UK labour market, experiencing high levels of racism and sexism (Healy, Bradley & Forson, 2011). In addition, African, Pakistani, and Bangladeshi women are less likely to be employed than white immigrants and White UK-born workers (Dustmann, Fabbri, Preston & Wadsworth, 2003).

While there are approximately equal numbers of male and female working-age migrants coming into the UK, there are differentials in their professional positioning, with men predominantly categorised as working in the software industry and highly skilled healthcare professionals while women are in the predominantly feminised professional occupations of nursing and midwifery (Rienzo, 2017). Equally important are the hourly wages of these migrants to the UK. In 2015, male migrants earned more than the female migrants, just as British male counterparts earned more than British female employees (Rienzo, 2017). These findings are in line with other research which shows that women must work harder for less money (Acker, 1980).

The disadvantages for women being concentrated in feminised occupations such as nursing, teaching and domestic work (Kofman, 2000) are further consolidated by women being excluded from the higher status roles within these occupations, and thus being 'othered' (Puwar, 2004; Bolton & Muzio, 2008; Adams, 2010). Women are often 'othered', excluded and marginalised, even in so-called feminised professions. For example, in the education sector, there is a high representation of women in nursery and primary school education, yet they are underrepresented in leadership positions. This is made possible by the feminisation processes in the professions and the labour market (Drudy, Martin, O'Flynn, & Woods, 2005). For example, in universities,

these feminisation processes include domination and devaluation, thus 'othering' and positioning women in lower status jobs as lecturers, in contrast to men, who are more highly positioned as readers or professors (Gaskell & Mullen, 2006). Similarly, there is an underrepresentation of women in medicine, particularly in certain high status specialities such as surgery (Acker, 1980; Adams, 2010; Bagilhole, 1993; Young, Noble, Hann & Sibbald, 2003).

Additional research points to the 'othering' of women in teaching, healthcare, and accounting occupations (Drudy, Martin, O'Flynn, & Woods, 2005; Nicholson, 2015), where they remain 'othered' in relation to the male colleagues, with the outcome being that they must 'prove' themselves (Adams, 2010; Richmond, 1995). In accounting, for example, there is a demarcation between female book-keepers and clerks compared to male accountants (Haynes, 2017; Loft, 1992), a demarcation similar to the historical predominance of female nurses and male doctors in healthcare (Adams, 2010; Puwar, 2004). Black women can be doubly 'othered' through an everyday construction of them as different from the majority population (Beale, 1979; Boyd, 1984; De Jong & Madamba, 2001; Farmer, 2016; Gay & Tate, 1998; Purdie-Vaughns & Eibach, 2008). This construction of Black African women as 'other' and 'different' limits their access to opportunities such as interesting work, monetary reward, and promotion (Collins, 2000; Purdie-Vaughns & Eibach, 2008).

For migrant female workers, such structural discrimination leads to significantly reduced economic opportunities (Boyd, 1984; Raghuram, 2004). For example, Nigerian female health workers are located at the intersection of multiple lines of discrimination in relation to their racialised and gendered identities (Evans et al., 2005). This means that while the UK labour

market has continually attracted highly skilled female migrants from Nigeria, these immigrants are clustered in low paid sectors such as cleaning, caring, and hospitality jobs (Evans et al., 2005).

In Evans et al.'s (2005) study with Nigerian women living in London, participants held graduate and postgraduate qualifications but worked as cleaners due to the saturation of the highly skilled labour market in London. Other research has shown that Black African and Black Caribbean women had difficulty securing professional and managerial jobs despite having appropriate higher education qualifications, and had lower earnings than comparable white groups (Clark & Drinkwater, 2007; Oikelome & Healy, 2007). In the medical profession, female migrants can also experience deskilling, marginalisation and gendered power relations (Kofman, 2000; Wojczewski et al., 2015), with recruiters preferring white males over Black candidates or white females (Acker, 1998, 2006; Farmer, 2016; Puwar, 2004).

Black African women are minorities in professional and managerial occupations within the UK (Farmer, 2016). In addition, there are documented experiences of immigrant women in the UK being clustered at the bottom of low paying roles such as sales assistants, factory and clerical workers, and so experiencing a loss of professional and social status (Aboderin, 2007; Evans & Bowlby, 2000) through mechanisms such as a 'blurry line' between white British carers and Black Nigerian nurses (Aboderin, 2007). Black African women thus experience a 'double jeopardy' of gender and racial discrimination, stemming from inequality and status degradation (Davidson, 1997) and including the need to overcome prejudices based on their foreign-sounding

names and accents as well as other identity factors that influence recruitment processes (Farmer, 2016; Lavergne & Mullainathan, 2004).

An important factor when considering migrant women's opportunities through access to employment is their role in the unremunerated responsibility of caring (emotionally, psychologically, physically, and socially) for dependants (Sweetman, 1998; Woodward, 1997). Although women can adapt behaviourally to a new culture, they often maintain, or are expected to maintain, the values about gender relations from their culture of origin, which tend to locate domestic responsibilities entirely with women (Dimitrov, 2004; Reynolds, 2001; Woodward, 1997). For some women, this means choosing familial roles over paid employment or deskilling to have access to paid employment while managing their significant domestic responsibilities (Evans & Bowlby, 2000). However, immigrant women may also negotiate their identities in relation to changing and contesting conceptions of feminine subjects in the UK and in their respective ethnic group (Evans & Bowlby, 2000).

The research reviewed above points to the ways in which migrant women experience work through the intersections of their gendered, racialised and ethnic categorisations (Phoenix, 2009), the importance of examining the ways in which these intersections might also relate to occupation and professional status, as well motherhood and gendered expectations. However, there is a paucity of research on Nigerian women living and working in the UK from an intersectional perspective, while the impact of professional status is a significantly under-

developed area of research. Completing this contextualising chapter, then, is the following section which outlines the concept of professional status.

2.6 Professional Status

This thesis sets out to examine the lives of female first generation migrants to the UK from Nigeria who are working in the healthcare sector. As discussed earlier, I am interested in undertaking an intersectional analysis of their experiences. Intersectionality will be discussed in more detail in chapter three. I have already talked about raced and gendered identities with regards to the subject of migration as well as the experiences of first-generation migrants in general, and in the UK more specifically. However, this is also a comparative project and I am interested in learning more about how professional status – an acquired status – might mediate the women's experience. I have already discussed why I chose not to adopt class as an analytical lens in section 2.4, noting specifically the fluidity and unreliability of class as an ascribed category in the case of migrants, and Black migrants especially. The section below develops those arguments by giving a detailed rationale for the use of professional status as an analytical lens in this study, and not class.

The Great British Class Survey, the largest study on class in the UK conducted by the British Broadcasting Corporation (BBC) in 2011, revealed the emergence of seven new categories of social class and depicted the traditional categories of social classification- working, middle and upper class, which represented only 39% of people, as outdated (Savage et al., 2013). Even in this new categorization, class is an extremely difficult identity category to measure, as it is based

on the perception of one's economic, social and cultural capital and how they interact, which is then used to position the individual on the socio-economic scale (Office for National Statistics, 2018). Further complexity is added when recognizing that the interaction between economic, social and cultural is dynamic, with the shifting subjective positionality that is characteristic of social mobility and diffusion reflecting a lack of clear distinctiveness in social class categorization. Social class is thus a nebulous and flawed factor for this study due to its subjective framework. This lack of clear distinctiveness in social class categorization is exasperated further in relation to the positionality of immigrants. Using the example of the Syrian doctor discussed above, a huge shift occurred in his economic capital in the process of migration, and even though he is willing to work and support himself, his migrant status as an asylum seeker in the UK has barred him from working in the UK. Dr. al-Zuebi's socio-economic status is thus subject to various interpretations; staying in Marriot hotel and owning a Rolex wristwatch might categorise Dr. al-Zuebi as upper class, whereas his inability to work because of his migrant status might position him differently. The complication inherent in measuring one's social class is made even complex by the process of migration, as social class is of limited use when comparison is made between countries, as what may signify upper class in Britain may be non-existent as a class signifier in countries such as Syria or even Nigeria. Combined, these explanations demonstrate the inherent and problematic ambiguities in utilizing social class as an analytical lens and as a mediating agency in the experiences of participants in this research study.

In contrast to social class, with professional status, there is a clear, distinct and objective categorization. The practice of medicine is an established and structured profession with a governing council and code of conduct, and although there are debates about the status of

nursing as a profession, it is also structured, with its on professional body who dictate the requirements and admit persons into its register deemed to have met the criteria to be registered nurses (General Medical Council, 2014; Nursing and Midwifery Council, 2018). It is this objective distinctiveness that informs the rational to use professional status, and not class, as an analytical category in this study.

Professional status also allowed this comparative study to explore two clearly distinguished professional statuses. Whereas, the use of class would have led to further divisions of these doctors and nurses when assessed based on multiple differentials in terms of their social, economic and cultural capitals. Two doctors with similar earnings may be positioned differently based on the differentials in social capital – the affluence of one's family and friends. Professional status, in contrast, offers a more stable analytical category in the case of this thesis because, as a qualification, it is tied to professional bodies and is therefore more tangibly acknowledged and less contested by others in everyday life. In addition, increasing one's professional status is one of few mechanisms by which migrants can improve their social status within a society and may therefore be an important coping mechanism.

Despite the likely importance of professional status as a tool for migrants to enhance their social and economic status, professional status, both on its own and at the intersections with gender and race is underexplored, suggesting an important contribution of this thesis is to offer such an analysis. I am therefore interested in examining how race, gender and professional status interact in shaping female migrants' experiences of working in the healthcare sector, of balancing their

work and family lives, and of making a home in Britain as Black women from Africa. What challenges do doctors and nurses face? Are these challenges shared? Does professional status mediate the challenges they experience? To be able to answer these questions, below, I foreground my analysis with a discussion of how professional status is defined, situating my work within the relevant debates.

Definitions of the term 'profession' are much debated and contested. For this thesis, I use the term profession in line with Freidson (1970) as it incorporates issues of power and is thus useful for an intersectional research project such as this. Freidson (1970, p. xvii) defined profession as "an occupation, which has assumed a dominant position in a division of labour, so that it gains control over the determination of the substance of its own work". Crucially, members of a profession serve the public interest (Lee, 1995), meaning that technically only those occupations which work in the interest of the wider general public are recognised as professions by Royal Charter (Aldridge & Evetts, 2003; Macdonald, 1985). Professions therefore gain this status by being organised bodies of experts (Abbott, 2014) who act in autonomous and self-directing ways to develop elaborate systems of instruction and training, entrance exams and other prerequisites (Evetts, 2003; Fournier, 1999; Freidson, 1994). 'Profession' is thus a social construct used to delineate those who are members from those who are not, with members of professions being afforded certain statuses, positions and privileges (Freidson, 1986).

Professions are understood as having power, as the process confers privileges to professionals such as the responsibility of meeting the demands of the market through managing space in the market and autonomy through a knowledge monopoly (Leigh, 2014). Undertaking qualifications

and engaging in essential specialist training to allow membership of a professional body thus offers a route to acquiring status (Abbott, 2014; Abbott & Meerabeau, 1998). From this perspective, membership of a professional body can be conceptualised as a status characteristic, which sociologists define as "any characteristic of actors around which evaluations of and beliefs about them come to be organized" (Berger, Rosenholtz, & Zelditch, 1980, p. 479).

Status characteristics can include those that are ascribed or those acquired/achieved (Webster & Hysom, 1998). Aboud (1988) defines ascribed identities as the pivotal aspects of one's sense of self, which are established during childhood and culturally ascribed. Culturally ascribed characteristics include one's sex or ethnicity, as in the statement about a newborn 'it's a girl!'. Other status characteristics can be acquired, including professional status as well as occupation or education (Berger, Rosenholtz, & Zelditch, 1980; Linton, 1936). Acquired status characteristics may allow people with low ascribed status characteristics to increase their overall status (Aboud, 1988; Hutnik, 1991). Equally, changes in circumstances mean people can also lose status (Neeley, 2013), with migration being one such change of circumstance, as discussed earlier in this chapter, and diminished status often being a characteristic of the experience of migrants. Bhugra (2004), for example, described migration as a process of social change, involving a sense of loss, dislocation, alienation, and isolation, as well as low economic and social status in the new geographic location.

However, within the context of status loss, individuals can acquire skills and special expertise to enhance and change their social and economic status (Neeley, 2013). Similarly, Thomas-Hunt and Phillips (2011), and Linton (1936) before them, argued that low status group members can

alter how they are assessed by others through effortful achievements, thus repositioning themselves on the social hierarchy. In this context, one route for migrants to enhance their status in their new country would be by acquiring status through professional training, meaning that professional status is an important, although often overlooked, characteristic in research on BME women's experiences of work. Professional status might be one method for migrants to enhance their overall status when entering the UK, as it allows a new, more positive, dimension of comparison through re-credentialisation (Hutnik, 1991; Lerner & Menahem, 2003). Professional status is also an important aspect of healthcare work, structuring the cultural and economic value of different people and the work they do in the health service. Again, this points to the importance of considering professional status in research on healthcare workers.

Not every occupation is a profession (Freidson, 1988; Macdonald, 1995). Professions are culturally considered to be of higher status than non-professional occupations, and limit access to membership, often through examinations or the development of qualifications managed by the professional body (Macdonald, 1995). The process of turning an occupation into a profession is called 'professionalisation'. Analysis of professionalisation includes the work of Wilensky (1964), who identified the processes that transform occupations into professions as: the creation of full-time occupation, establishment of a training school, and formation of professional associations. Later, Abbott (2014) added the formation of a code of ethics as a requirement.

Keogh (1997) posits that professional recognition is an essential part of the process of professionalisation, but that this differs from country to country. In general, however, professions

are characterised by a high degree of autonomy or self-regulation, knowledge monopoly, control, and social closure (Hamilton 1992; Keogh, 1997; Waddington, 1990). Social closures engender boundaries between the discipline community and the public, through the institutionalisation of knowledge and skills (Freidson, 1986). Social closures also meet a range of cultural, social and psychological needs of individuals who are recognised as professionals (Leigh, 2014).

Professionalisation is therefore a project that focuses on the securing, enhancement, and social and economic standing of its members (Macdonald, 1995). Professionals occupy specially protected positions in society (Freidson, 2001; Larson, 1979), and it is through professionalisation that occupations create and restrict a market for their services while also claiming special privileges for their members (Bailey, Tisdell & Cervero, 1994). This 'power approach' to understanding professional status thus emphasises the ways in which the professionalisation of occupations and the attainment of professional status for individuals secures and reproduces privileged positions in society.

Medicine is a historically established profession that has consolidated high-status through the professionalisation process. Medics, who are associated with valued and complex knowledge and skills, get special legal and institutional privileges from the state and society (Burrage & Torstendahl 1990). The high status medicine has gained through the professionalisation process has inspired other occupations towards pursuing professionalisation (McDonald, Campbell, & Lester, 2009; Neal & Morgan, 2000). Indeed, the professionalisation of certain occupations was a target of previous UK government administrations (Hugman, 1996; Neal & Morgan, 2000),

who focused on professionalising nursing in the late 20th century by tying nursing training to university graduate education, a standardisation of knowledge and the market control of the profession (Bartlett, Simonite, Westcott, & Taylor, 2000; Girot, 2000; McDonald, Campbell, & Lester, 2009). However, the cultural professionalisation of nursing was only partially successful (Elkan, & Robinson, 1993). Nursing is often considered a semi-profession rather than an established, recognised profession (Bolton & Muzio, 2008; Bridges, 1990). This is despite the milestones achieved since the foundations of professional nursing laid by Florence Nightingale in the 19th century, Henderson in the 20th century, and later attempts at professionalisation through university qualifications.

What else distinguishes the status of doctors and nurses? Sociological analyses of professionalisation processes have demonstrated the ways in which professions are classed (Macdonald, 1995; Abbott, 2014; Johnson, 2016), gendered (Adams, 2000, 2003, 2005, 2010) and racialised (Palmer, 2016; Shields and Price, 2002; Troyna, 1994; Van Dijk, 1993). Bledstein (1976) notes that professionalisation was a means for the middle class to gain cultural control as well as to increase their social status. One factor that influences the success of a professionalisation process is gender, as defined by the sex ratio of people working in that field (Crompton & Lyonette, 2011). Culturally speaking, sex categorisations tend to be organised hierarchically, with men having higher status than women. Loft and Kirkham (2003) demonstrate how men have historically employed discursive boundaries to other, often feminised, aspiring professions as part of the professionalisation processes. The accounting profession offers an example when it denied women entrance to the profession – even after women proved that they were capable of doing the job in question when covering for men away at war – on the grounds

that the work the women were performing was merely 'bookkeeping'. Parallel distinctions are found in the medicine/nursing dichotomy. Indeed, the Accountant, the leading professional publication of the time, argued in 1917: "There is as much difference between a bookkeeper and an accountant as there is between a nurse and a doctor, or between a dental mechanic and a dentist" (Kirkham & Loft, 1993: p. 507). The former is thus presumed to be about the application of technical knowledge, the latter about judgement.

However, this distinction between mere application on the one hand and judgement on the other is easily disrupted. For example, in his study of patterns of nurse-doctor interactions, Hughes (1988) argued more than 30 years ago that nurses were involved in diagnosis, thus blurring the boundaries between these two professional spaces. The introduction of multidisciplinary teams in the NHS marked a further disruption to power relations (Fleissig, Jenkins, Catt & Fallowfield, 2006). Multidisciplinary teams were introduced to the NHS as an egalitarian enterprise, according to Warelow (1996), where the person with the most expertise in any given situation would take a leadership role. However, Warelow (1996) found that in practice, multidisciplinary teams revert to stereotypically (masculine) role allocations in which the doctor assumes the role of the team leader. Interestingly, during the introduction of primary care in Sweden, the introduction of multidisciplinary teams was considered a failure due to the refusal of general practitioners to participate (Hansson et al., 2010). Hansson et al. (2010) point to several studies focusing on the analysis of teamwork in healthcare settings which found a positive relation between a person's educational attainment and his or her refusal to cooperate. Interestingly, in Hansson et al.'s study, neither gender nor age mediated the findings, and women doctors were

not found to be more likely to cooperate in team situations. No reference was made to race in this study (Hansson et al., 2010).

Tensions in power relations have been examined in several other works. In a study with 60 doctors and nurses, both male and female workers as well as those of different ethnic backgrounds, Leonard (2003) found that the new managerialism of the NHS helps nurses renegotiate their status in certain situations, but within a context of a relentless positioning and repositioning of oneself. That repositioning takes place relative to others, and is therefore a complex interplay between one's own ascribed and acquired status positions as well as that of others. This underlines the importance of examining professional status with an intersectional lens.

While there is limited work on the professional status of the healthcare personnel, research to date suggests that the higher an individual's status, the greater their psychological safety and security (Nembhard & Edmundson, 2006), and that professional status shapes the environment for interpersonal interaction (Alderfer, 1987). Considering the literature specifically on doctors and nurses, who have differing professional status, this chapter has noted that previous research pointed to commonalities between ethnic minority nurses and doctors in terms of the devaluation/non-recognition of overseas qualification, deskilling and racism (Connell, Zurn, Stilwell, Awases & Braichet, 2007; International Organisation for Migration, 2002; Likupe, 2006). However, nurses had different experiences from the doctors in terms of a lack of career progression, lack of respect, and greater discrimination in pay and condition of service (Hardill

& Macdonald, 2000; Likupe, 2006; Royal College of Nursing, 2003). Doctors experienced differences from the nurses in areas including sexism, access to the worst jobs and reduction in grade (Kangasniemi, Winters & Commander, 2007; Robinson & Carey, 2000;). Focusing on race, however, an ethnography from Porter (1993) examined the question of how racism impacts on the professional relationship between doctors and nurses. The author describes ways in which "criticisms of immigrant doctors' competence can be seen as the vehicle through which racism is expressed" (1993, p. 605). On the one hand, those subjected to racism were able to draw on their knowledge in negotiating the power relations with others, while on the other, Porter reports a "relentless undercurrent of racism in the attitudes of some of the nurses" (1993, p. 602) and noted that the relationships between white nurses and Black doctors were particularly strained and more formal than between white doctors and nurses.

Almost 20 years later, focusing on the Swedish context, Salmonsson (2014) reports similar occurrences. Drawing on interviews with 15 migrant doctors, her work reveals the ways in which doctors from migrant backgrounds working in Sweden belong to one of the most privileged groups in the country while simultaneously struggling with what Salmonsson (2014) describes as the boundaries of belonging. She details the racism in interactions with other medical staff and patients which migrant doctors are subjected to on a daily basis as well as the ways in which their expertise is casually, overtly and regularly questioned. As in Leonard (2003), Salmonsson (2014) also notes that the experience of what she refers to as 'assigned migranthood' is importantly related to with whom this migranthood is negotiated on a daily basis and what their social status is, again highlighting the importance of adopting an intersectional lens in my analysis. This will be explored in more depth in Chapters 3 and 4.

2.7 Conclusion

In this chapter, I have outlined the social, economic, political and historical context of the thesis. Reviewing the literature on immigration in relation to Nigeria and the UK, gender, race, and by considering the role of professional status in mediating the experiences of migrant workers in the healthcare sector, this chapter has shown the importance of an intersectional lens in making sense of the experiences of migration. In addition, I here note both the paucity of work that puts women's experiences at the forefront of the analysis of migration, and of that which draws on critical race studies to think through those women's experiences, as structured by the intersection of multiple social categories. In considering the ways in which some migrants are trapped in a low social status in their host country as well as how training towards professional status might improve this status, the chapter also provides the rationale for a novel aspect of this thesis, namely considering professional status, along with gender and racialised identities, as part of the social categories important for an intersectional analysis of the experiences of health worker migration. This chapter thus explains the logic behind the research questions of this thesis, namely:

1. *How do gendered and racialised identities affect the experiences of female Nigerian healthcare migrants working in the NHS?*
2. *To what extent does professional status mediate these women's experiences of living and working in the UK?*

This chapter has contextualised and justified the questions structuring this thesis, and highlighted the importance of ascribed and acquired identities to migrant doctors and nurses' experiences.

Following on from these issues, the next chapter will describe the conceptual framework I draw on for thinking about identity and the intersections of gender, race and professional status.

CHAPTER 3 THEORETICAL FRAMING: IDENTITIES, INTERSECTIONALITY, INEQUALITIES AT WORK AND COPING

In chapter two, I described how the process of migration can lead to changes in individuals' ascribed and acquired identities, arguing that migration can have profound effects on how people understand themselves and are understood by others, creating a context in which migrants often develop complex, multiple identities. In addition, I introduced the professional space of this investigation - the British healthcare sector - and discussed professional status as an important aspect to intersectional analyses of the lived experiences of migrant workers.

In this third chapter, I discuss the theoretical frame that guides my work. In order to conceptualise migrant identities, this thesis sought a framework that positions identity as contextualised, multiple, and fragmented. Such a framework is offered by the cultural studies approach, in particular the work of Stuart Hall, which is discussed in-depth in this chapter. In addition, I consider the ways migrant workers psychologically cope with their status as 'other'. Finally, my work recognises that organisations such as the NHS are important spaces where inequalities are maintained and reproduced, not just through interactions and relationships, but also through organisational structures (Kokot, 2014). To think about the ways in which organisations pattern experiences of inequality, I will draw on Acker's (2006) concept of inequality regimes.

3.1 Conceptualising Identity as Multiple, Fractured, and Contextual

Central to Hall's (1996a, 1996b) work is the idea of identity being fragmented and fractured through the context of modern living, which is characterised by a colonial past and a globalised

present. This work draws on social constructionism to conceptualise gendered and racialised identities as a construct produced within a particular socio-historic context, and offers an important framework for thinking through contemporary identities at the intersections of gender, race, and ethnicity in the context of immigration to the UK. This chapter therefore starts by outlining the conceptualisation of identity in cultural studies as multiple, fragmented and context based, before outlining how this conceptualisation can offer a framework for thinking through notions of race, ethnicity, and gender.

Central in the work of cultural studies' researchers is an understanding of identity as being produced through difference, resulting in complex, multiple and multi-layered identities (Gupta & Ferguson, 1992; Woodward, 1997). The perception of difference, both visual or linguistic, is understood as leading to the categorisation of individuals, which then structures everyday interactions. For example, the common modern-day identity-themed question, 'where are you 'originally' from?', often asked people of seemingly ethnic minority identity in a specific geographic location, is a response to linguistic and/or visual difference. Hall (1996a) argues that answering this question has become more complex, due to the impact of factors such as historical colonialism and contemporary globalisation which means that people are multiply located, and so can assume different identities, at different times, in different spaces. Colonisation, globalisation, capitalism, the formation of the world economy, and the social and sexual division of labour are all seen to be important factors influencing identity, meaning that identity is understood as emerging within the operation of modalities of power, and is thus a structural positioning (Hall, 1997b; 1996b; Winant, 2000).

This conceptualisation of identity as being a 'shifting', 'fragmented' and 'fractured' structural positioning can best be illustrated by the discourse on identity between two friends who identify as 'two Black girls from London', as discussed by Hall (1997a). From Hall's perspective, the migration of these friends from the UK to the US highlights the fragmentation, de-centring and shifting of identity. In the UK, the girls identified as Jamaican/Caribbean, but in the US, their British accents made them linguistically different, causing others to identify them as African English, rather than Jamaican/Caribbean. In this example, Hall sees social processes, such as globalisation and migration, precipitating the fragmentation and de-centring of identity, causing racial and ethnic subjects to be 'sutured' into the social structure of the specific society in which they find themselves (Hall, 1997a).

From this perspective, Hall (1990) conceptualised identity as a 'production' that is never complete and always in process. The fluid, shifting nature of identity is characteristic of late-modernity, in which old identities are destabilised in order to give rise to new ones (Hall, 1997a, 1996a, 1992). This is in contrast to other models of identity as relatively fixed and stable (Hall, 1996b). This fluidity also contrasts with cultural studies' analysis of historical shifts, such as how identity was conceptualised during the enlightenment era as fixed at birth and remaining unchanged as life unfolded, to identity being an essence of self that is continually formed and reformed as the self interacts with a shifting cultural, economic, and political landscape (Hall, 1996b). In this shift, identity is not constructed as concerned with 'being' but rather 'becoming'. Distinctions are also made between the 'becoming' of identity as an ongoing process that involves the individual being shaped by their context and interactions with others, whereas the

identity of 'becoming' as a project involves the more agentic shaping of a new identity by the individual (Yates & McLeod, 2006).

Contemporary identities are thus conceptualised as continuously formed and transformed, and always in process (Hall, 1996a). They are fragmented, unstable, constantly changing ways of being, involving the dislocation, displacement, and transformation of previous identities. This is not just because people travel, but also because cultural ways of understanding difference change. Across history, the construction, representation, and meaning of ethnic and racialised identities change in relation to other ethnic groups, meaning that categorical terms are always in flux (Woodward, 1997).

For example, Hall (2000) argued that the colonial and postcolonial subjects from Africa, Asia, and the Caribbean who immigrated to the UK were initially identified under ethnic identities respectively as African, Asian, and Caribbean, but were then mobilised under the single political category 'Black'. Gilroy (1992) noted that the arrival of African people in the UK dislodged Caribbean people from the centre of 'British Blackness'. Currently, terms such as Black and Ethnic Minority (BME) which are used to refer to, and represent, visible ethnic minorities in the UK have been criticised as being outdated (see for example the comments of Trevor Phillips, the former chairman of the Commission for Racial Equality in Ford, 2015).

Analysis of the experiences of Nigerian immigrants in the UK therefore requires consideration of their identification and positionality as ethnicised and racialised subjects in the UK, which is in turn historically, politically, and culturally constructed (Hall, 1996c). The positionality of many

Nigerian immigrants in the UK occurs around having to negotiate their collective identity as 'Black African'. Aspinall and Chinouya (2016) argue that the collective identity of 'Black African' is: "an embodiment of colonial and post-colonial histories and politics that continue to shape aspects of their [Black people living in the UK's] lives through a variety of structural processes" (p. 222). Similarly, Hall (1996c) states that 'Black' is a political and cultural category framed to position its subjects at the margins and is based on the representations and stereotypes of Black subjects as inferior. From this perspective, a Black/white paradigm of race is produced as a problematic colour line that produces and reproduces racial hierarchy.

In the Black/White paradigm of race, both Black and white categories are perceived as aspects of the same historical condition; that is, colonisation (Singh, 2004 citing Du Bois). Colonisation thus produces the 'Black African' identity, with Andrews (2016), for example, proposing the idea of Black as a country based on a diasporic connection of colonised and visible minorities who are oppressed by racism (Andrews, 2016; Maylor, 2009). Through racism, Black subjects are produced, with people who are constructed as 'Black' having to navigate 'impassable symbolic boundaries', that is, spaces which have been constructed to exist between racially constituted categories (Hall, 1996c, p. 445).

However, Andrews (2016) argues that racial inequality operates in more nuanced ways than those imagined through the Black/white paradigm, since analysis of racism in the UK reveals differential experiences for the different ethnic minorities living in the country (Dustmann, Fabbri, Preston, & Wadsworth, 2003; Clark & Drinkwater, 2007; Catney & Sabater, 2015). From this perspective, it is important to both consider the ways in which Nigerian health workers in the

UK might have to negotiate a 'Black African' identity, but also the ways in which other identities associated with being Nigerian may impact on their experiences. These identities are theorised to locate a person within a nexus of difference because a key aspect of how identity is produced is through the construction of difference in relation to the 'other' (Hall, 1996a; Woodward, 1997).

Identity is constructed through splitting between the one and the other; it is always discussed, narrated, and processed from the position of the 'other' within representation (Hall, 1997c). Identification is therefore constructed through ambivalence and splitting between what one is and is not (Hall, 1997a). This is linked to the findings of Salomonsson (2014) and Leonard (2003) which were discussed at the end of chapter two. Both revealed that the doctors who participated in their research found that power relations were constantly renegotiated depending on the people with whom those doctors were engaging. One's professional status forms part of one's identity but it is not static, rather it is always being dynamically negotiated in relation to others.

Collective identities in particular are understood as a continuous process, involving affirmation, change, or negotiation. Greene (2010) illustrated this viewpoint in her description of her family's constantly changing identity as they moved from being called 'negroes' to 'coloured' to 'Black' and now 'African American'. Greene (2010) argued that this constantly changing process of identification was based on historical knowledge and was shaped through interactions with other key people in the course of her development. Greene's view of identification illustrates how the construction and representation of identity is embedded in historic moments, and exemplifies

Hall's view (1990) of identity as a production which is never complete, and always constituted in representation.

Multiculturalism increasingly characterises the context into which migrants move, creating particular contextual demands on identity production (Lalonde, Taylor & Moghaddam, 1992; Hall, 1996c; Sarup, 1996). As the world becomes more globalised and multicultural, identities get displaced, increasing their chances of being multiple or hybrid (Sarup, 1996; Arnett, 2002). While broadly supporting cultural studies' conceptualisation of identity as a process of 'becoming', Ang (2000) argued that there should be greater analytical attention given to the discomfort and challenges that accompany individuals in their journey of 'becoming', especially in a new social or cultural space. The challenges, ambivalence, and discomfort experienced by individuals who are involuntarily obliged and expected to go on this journey of 'becoming' can create uncertainty and distress (Ang, 2000; Yates & McLeod, 2006). From this perspective, migration can be understood as a social change that has the potential to affect an individual's social identity to the point of profound and distressing reorganisation and redefinition (Amiot, De la Sablonnière, Terry & Smith, 2007).

The reorganisation required for immigrants depends on the context, time, place, and historical moment (Wodak & Krzyzanowski, 2007). People always try to find some ground; a place, or position on which to stand depending on the context or situation (Hall, 1997a), and therein lies their identity, or identities, reflecting the membership of the multiple social groups to which an individual can belong (Roccas & Brewer, 2002). It is therefore pertinent to understand the structure of multiple social identities, including those related to gender, racialised, ethnic and

immigrant identities, in order to aid our overall understanding of social identities and identification. For this reason, the following sections outline how such identities are conceptualised in this thesis more specifically with regards to migration, race, ethnicity, and gender. The chapter will conclude with a discussion of intersectionality, where I will revisit the subject of professional status.

3.1.1 Migrant Identities

The challenges and experiences faced by new immigrants in their destination country are influenced by several factors, including the personal and social identity of the immigrant and the social position of those identities in the new environment (Boyd & Grieco, 2003). The experience of immigration thus involves negotiating social positionality within the existing social structures of the host country (Hall, 1996c). Migration involves the movement, displacement, and dislocation of people as they enter new spaces, and their attendant social structures. Salter (2003), for example, described refugees as the dispossessed, excluded from the universal categories of 'citizens' and 'nation', and emphasising the ways in which they have been constructed as a problem (Sales, 2002; Bhatia & Wallace, 2007).

There are differences between different groups of migrants; notably the experiences of asylum seekers and refugees will be different to those of economic migrants. However, while recognising their significantly different motivations for moving, similarities can be drawn across these groups in terms of the identification effects they experience when border-crossing into the

UK, in particular the loss of status, as discussed in chapter two, and developed further below in relation to identity.

The crossing of geographic borders and boundaries is a common practice in every society, but often involves important identity shifts (Bhugra, 2004; Easthope, 2009; Vertovec, 2001). In this section, I therefore review research on the identification processes involved in geographic border-crossing into the UK. The section will delve into understanding the categorisation of immigrant identities in Britain, the construction of immigrant identities in Britain, and the British public's perception of an immigrant in the British context, based on Hall's (1997c) work on identity and representation.

A key point in the identification process for an immigrant starts at the border, where official categorisation of each individual determines their entry or refusal of entry into a country. At the border, all immigrants go through the identification process - passport check - and placed into groups according to the linguistic categorisation of immigrants, economic migrants, refugees, asylum seekers, expatriates, entrepreneurs, students, or tourists. The migration journey therefore specifically changes one's identity at the border (Sarup, 1996). While borders represent invisible demarcations, they are powerful in their creation and maintenance of new and distinct identities which structure experiences and create new senses of the 'self' and 'others' (Donnan, 2001).

Part of the power of these categorisations is that they are linked to wider social and political representations (Sarup, 1996; Wilson & Donnan, 1998). Hall (1997c), for example, argues that

through language, we produce thoughts, ideas, and feelings about certain people, which are then shared in social interaction. Social representation within the context of collective identities is shaped by the institutional definitions of identities. Political institutions and policies are powerful instruments that influence the overall experiences of immigrants (Deaux, 2006) because they are an important source of social representations of immigrants that are circulated in daily social interactions and through the media (Andreouli & Howarth, 2013; Deaux, 2006). Thus, stereotypes and ideas about immigrants which are produced from government policy and discourse, such as notions about immigrants' contribution or non-contributions to wider society, circulate widely. Mio (1997, p. 121) posits that politicians and the media used symbolic representation in their language to stir up emotion, bridging the gap between the logical and the emotional, thus reiterating Hall's (1997c) assertion about the positioning of identity through representation, language, and meanings. Examples of such emotive language can be seen in the 2005 British National Party (BNP) manifesto, which used the phrase '*reversal of the tide of migration'* (BNP 2005 Manifesto cited in Chateris-Black, 2006), while in 2004 they used the phrase '*stop this new influx*' that is about to '*engulf us'*. Similarly, the Telegraph newspaper referred to an '*immigration crisis'* that has '*engulfed'* Tony Blair's government (Charteris-Black, 2006). It is important to consider the symbolic representation of immigrants in this kind of public and political discourse in terms of how it might structure the experiences and identities of immigrants entering the UK (Blinder & Allen, 2016a; Blinder & Jeannet, 2014).

Media coverage of immigration presents conflicting and confusing issues to the public, since metaphors of immigration and immigrants construct and categorise immigrants as both desirable and undesirable (Anderson, 2013; Charteris-Black, 2006; Sales, 2002). Immigrants in the UK

may be constructed as desired and sought after since they represent the solution to skills shortages in the UK workforce, particularly in the healthcare sector (Blinder & Allen, 2016b; Likupe, 2006). In his analysis of media representations, Elliott-Cooper (2016) echoed this perception of immigrants as 'useful labour' and posited that positive perceptions of and predispositions towards immigrants in the UK are linked to the support of left-wing political parties (Norris, 2005; Van Der Brug, Fennema, & Tillie, 2000).

Immigrants are, however, also frequently represented in negative ways as 'unwanted outsiders' who have the potential to deplete the resources and wages of the indigenous people; alternatively, they may be associated with fears of terrorism and invasion by alien 'others' (Charteris-Black, 2006). There are suggestions that British politicians, particularly those from right-wing parties, as well as the media have contributed to a visibly negative coverage of immigration in Britain, encouraging an ill-disposition in the British public towards immigration and immigrants, particularly in those who support right and centre-right parties (Blinder & Jeannet, 2014; Charteris-Black, 2006).

The construction of certain immigrant identities as problematic, unwanted, and undeserving often stems from their perceived status as non-contributors to the system (Blinder & Jeannet, 2014; Sales, 2002; Salter, 2003; Sollund, 2012). Immigrants have been constructed as "unworthy beneficiaries of welfare and affirmative actions" (Ferree, Lorber & Hess, 1999, p. 12). Ford (2011) argued that while the term 'immigrants' suggests the classification of an 'undifferentiated mass', there is strong evidence that immigrants are differentiated by European people into 'acceptable' and 'unacceptable' categories. The reception immigrants receive in their destination

country is therefore dependent on their perception and representation in public space. Being categorised as an 'acceptable' or 'unacceptable' immigrant is often based on perceived understandings of an immigrants' contribution to the host society, which in turn can affect an immigrant's experiences of hostility or exclusion from others (Hainmueller & Hopkins, 2014). Those considered culturally distinct or who are perceived to be drawing on resources are often constructed as problematic. It is therefore clear that the way migrants are categorised then affects whether they experience a hostile or welcoming experience (Lewis, 2006; Sollund, 2012).

However, positive attitudes towards a certain group of immigrants can occur when they are considered less dependent on health and welfare systems and capable of supporting themselves. Such groups of people are often determined in terms of their professional status, and include doctors, nurses, and teachers (Blinder, 2015; Crawley, 2005; Saggar, 2003). This further supports the decision in this thesis to focus on the role of professional status in shaping the experiences of migrants in the UK.

The ways in which immigrants are positioned within wider social and political discourses thus affects the kinds of interactions they have with others, which in turn affects how they perceive themselves. Social identities are limited by borders and boundaries, and the process of migration is one in which a person has to re-learn who they are as they become someone different, in line with Hall and others' argument that immigration is a process of moving from 'being' to 'becoming' (Hall, 1996c; McLeod & Yates, 2006; Sarup, 1996; Wodak & Krzyzanowski, 2007).

For migrants, this process of becoming involves not just a negotiation with the social and political discourses of immigrants of their host country, but also a negotiation with the identities they held before they travelled. Past identities might be hard to maintain in a new context, creating fragmentation and fracture. This results in the migrant being both here and there (Sarup, 1996), holding some valued and thus salient identities from their past which are considered relevant to the current self but unable to be expressed. For example, chapter two presented the case of a cosmetic surgeon from Syria who was categorised as an asylum seeker in the UK, and was therefore not entitled to work. For this doctor, professional status could not be expressed, meaning that through the conceptualisation of fractured identities, it could be suggested that such a person would still hold aspects of the (past) identity of surgeon while not being able to live these out in the present.

Emigrating to a country in which the dominant discourse on immigrants is hostile poses significant identity challenges for migrants that can be debilitating. However, the re-composing process of migration can also be transformative in positive ways that may feel empowering and creative (Geddes & Scholten, 2016; Sarup, 1996). The re-composing process in this context refers to the social process through which ethnic minority immigrants make deliberate and strategic efforts to improve their social mobility and stability in their new destination, disrupted by migration. They attempt to improve their social mobility by earning social and cultural capital that aid their adjustment to life in a new society and to maintain a healthy sense of self. For example, the destination country can be culturally different in ways that raise hopes and expectations with the appropriate social and cultural capital in place (Boyle, Halfacree & Robinson, 2013; Castles, De Haas & Miller, 2013) and which can potentially offer a range of

other benefits such as a stable family income and better educational opportunities (Castles et al., 2013). This is despite challenges that range from a loss of social support after family and friends are left behind in the home country, as well as lower entitlements and status, and the need to learn how to access opportunities and resources (Deaux, 2006; Sales, 2002).

The process of 'becoming' can also involve consolidation. Over time, or certain developmental periods (such as young adulthood), individuals can strengthen particular identities, developing a more coherent sense of self (Deaux, 2006). Thus, it is important to consider migration as a process that might involve different stages in which identities are more or less in flux. Also important is the notion that although migrants are sometimes treated as a unitary category, they represent a diverse group of people. The ways in which immigrants are located ethnically, racially, linguistically, as well as religiously affect their experiences of migration (Ford, 2011). The next section will therefore develop further the thesis' exposition of the cultural studies approach to race, and the impact of constructions of 'Blackness' and racial difference on the experiences of immigrants.

3.1.2 Racialised Identities

When the Empire Windrush ship arrived in Britain it not only marked the beginning of mass migration of non-white colonial identities, but also the beginning of new race relations in Britain (Carter, 2000; Spencer, 1997). The coming of these immigrants from the Caribbean countries was orchestrated by the British government for the purpose for nation-building and to meet the demand for labour after the second world war. However, this move also precipitated the

racialisation of division and organisation of labour in the UK (McDowell, 2009; Small & Solomos, 2006).

The racialised organisation of labour meant that Black men and women ended up in a range of working-class jobs such as domestic servants or barmaids, while white immigrants were deemed to be suitable for other more prestigious jobs (Bressey, 2010; McDowell, 2009). The (in)visibility of immigrant bodies – as a result of 'race' – played and still plays a significant role in the division and organisation of work (Bressey, 2010; McDowell, 2007, 2009) in multi-cultural, multi-racial, and multi-ethnic societies such as Britain (Mason, 2000; McLaren & Johnson, 2007), hence the need to explore the concept of race, racialisation, and racialised identities.

The ways in which race is constructed and classified has shaped the experiences of many immigrants through the years and has eventually resulted in the differential positioning of racialised identities in the UK (McDowell, 2007). It is therefore pertinent to discuss the concept of race and racialised identities in the context of people doing different work in different jobs. Race has been described as the social category with the most significant identity characterisation process in modern Britain (Mason, 2000), with Gilroy (2000, p. 11) saying: "it is impossible to deny that we are living through a profound transformation in the way the idea of 'race' is understood and acted upon". Gilroy (2000) believes this transformation to be the result of historic conditions, and that this history can be traced back to the voyages of discovery, conquests, colonisation, and migration (Andreasen, 1998; Anthias & Yuval-Davis, 2005). This section will therefore examine the different conceptualisations of race in more depth.

The biological perspective of race is based on biological human characteristics (Andreasen, 1998, 2004; Harrison, 2010; Winant, 2000). Harrison (2010) questions how meaningful racial differences can be, as expressed through the assignment of cultural differences to genetic inheritance, if all human beings are 99.9% alike, as suggested by the biological analysis of human genomes. Lopez (1994) posits that as far as biological race is considered, genetic differentiation is usually a function of geographic separation and, as such, there is greater genetic difference between, for example, Spanish and Swedish people than Spanish and North African people. Thus, Lopez (1994) concludes that the conceptualisation of racial differences on the basis of genetics is an illusion.

This study will focus on the social constructionists' conceptions of race, exploring the meaning and representation of racial groups, and the ways in which the social construction of the concept of 'race' shapes life experiences in a socially stratified society. This social constructionist view of race is something critical race theorists agree on, as noted by Delgado and Stefancic (2017). Race is not something that is inherent or objective; rather, "races are categories that society invents, manipulates, or retires when convenient" (Delgado & Stefancic, 2017, p. 3). These authors further note that:

> *"[people] with common origins share certain physical traits, of course, such as skin colour, physique, and hair texture. But these constitute only an extremely small portion of their genetic endowment, are dwarfed by that which we have in common, and have little or*

> *nothing to do with distinctly human, higher-order traits, such as personality, intelligence, and moral behaviour"* (Delgado and Stefancic, 2017, p. 3).

When analysing a United States court case in which a Japanese person who was 'white in colour' was excluded for not meeting the 'white person' criteria of the Naturalisation Act, Lopez (1994) concludes that race is a function of many factors besides skin colour, further highlighting the ways in which race is socially constructed, and thus a concept that is associated with different meanings at different times and in different locations. Roediger (2002) emphasises the variation inherent in the construction and classification of race, and indicates that there are degrees of whiteness and Blackness, and distinctions within the binary categorisations of race which impacted upon the construction of the hierarchy of whiteness and Blackness in the British labour market (McDowell, 2009). For example, the UK perceives a varying degree of 'acceptability' between Polish people and those from the other A8 countries as well as Germans and French people despite their common whiteness; and also a varying degree of Blackness amongst non-white immigrants from the sub-continental Asian communities (Indian, Pakistani, and Bangladeshi), African and Caribbean communities (McDowell, 2009; Spencer, 2002). Hence, race is said to be mediated by factors other than skin colour, such as class, language, geopolitical distance.

However, despite the rejection of the reality of race by critical race theorists, Harrison (2010) and Montagu (2001) acknowledge the profound influence of the social construction of race on human lives. Race is a powerful construct, capable of mediating every aspect of our daily lives, as it underpins the formation and breakdown of political alliances. It is subsumed by ethnicity

(Gilroy, 2000; Lopez, 1994) and nationalism (Anthias & Yuval-Davis, 2005), and is viewed as a proxy for class (Gilroy, 2000). As such, it is a determinant of economic prospects (Lopez, 1994). Race has been conceptualised as a 'product' of social structures whereby arrangements such as the segmentation of the labour market, segregation of residential accommodation, and the stratification of government benefits produce race (Ferree, Lorber & Hess, 1999). Gilroy (2000) cited Gabriel and Ben-Tovim (1979), explaining that the categorisation of race relations reflects the analysis of structures, culture, and meanings. However, race is also about othering, boundaries and binaries.

As discussed above in the introduction to the cultural studies approach to identity, 'Black' is a historical, cultural, and political category (Hall, 1997a). In Britain, while 'Black' is a signifier inscribed in the skin (Hall, 1996e, 1997a), it is also beyond the pigmentation of the skin. In his work, Hall recollects how he explained to his two-year old son that he was not brown but 'Black', signifying the consciousness and learning of one's identity from the position of the 'other' and as a learning process embedded in the identification process. Conceptualising race visibility based on skin colour invites various interpretations and meanings (Ferree, Lorber & Hess, 1999).

The white/Black binary paradigm of race has been criticised as being exclusionary in nature (McDowell, 2009; Perea, 1994). The term 'Black' was socially and historically constructed in the wake of decolonisation while the consequence of nationalistic and ideological struggles symbolised 'Black' as a negative factor (Hall, 1997a; McDowell, 2009; Tsri, 2016), a contrast from whiteness, which depicted as purity and cleanness (McDowell, 2009). As a political term,

‘Black’ has been constructed in Britain to connote people of African, Caribbean and South Asian origins (Malik, 2002; Modood, 2005). However, the concept of the ‘Black’ identity is perceived as a ‘confined space’ for communities from the former colonies of the British empire, otherwise known as the New Commonwealth (Modood, 2005).

British Asian people have rejected the concept of Blackness, perceiving it as a political colour leading to a politicised identity, but positing that this identity can be a thing of ethnic pride for African people (Modood, 2005). Tsri (2016) argues that Africans are not Black, as the Black/white dichotomy is used symbolically to connote both good and bad traits, in which Black represents inferiority and white represents superiority, as a result of a long-standing conceptual relationship. Similarly, Jordan (1974) argued that the Black and white contrast was the conceptualisation of race based on emotions; while ‘white’ represented purity, goodness, and virginity, ‘Black’ depicted death, evil, and debasement. Hall (1997a) states that it was in Britain that he experienced a redefinition of identity through being identified as ‘Black’, whereas in Jamaica, people are identified by a range of shades of brown.

The rejection of the concept of Blackness is based on the perceived representation of race and Blackness via the British media as well as the ways in which these images and representations underpin and maintain racial superiority and supremacy, and consequently maintain systems of racial domination (hooks, 1992). The stigmatisation and hegemonic representation of Black people are embedded in historical, relational, and contextual encounters in social systems and institutions in Britain (Howarth, 2006). Hall (1990) emphasises the positionality of identities through constructed images; the various ways in which we are positioned and in which we

position ourselves within and in relation to the 'other'. The perception Black people have of themselves, and the perception 'others' have of Black people, is defined and controlled by constructed images, which also grants Black people access to social and political power (hooks, 1992).

Recent adverts for Pears soap and Nivea skincare brand have symbolically represented 'Africa as dark and its people as dirty', and there is an undertone of racial superiority in such adverts (Hirsch, 2017). The cognitive negative belief associated with Blackness or Black identities (Biko, 1973; Howarth, 2006) is the basis on which the repeated representation of those identities reinforces the institutional and structural positioning of them as being at the bottom of the hierarchy. Fanon (1952) described the feelings of inadequacy and dependence that people with Black identities experience while residing in what he called 'a white world'. Fanon's (1952) view buttresses hooks' (1992) viewpoint about how entrance into certain social systems and institutions leaves Black identities unprepared for confronting and challenging white racism, as well as how Black identities seek the company of other Black identities as a coping mechanism. The concept of coping strategies employed by racialised, Black identities will be discussed in section 3.3 below.

3.1.3 Ethnic Identities

Britain became recognised as multi-ethnic in the aftermath of the Second World War, following mass migration from Europe and the Caribbean, Indian and African communities (McDowell, 2009). The argument over what constitutes an ethnic identity resumed due to the persistent

cultural, linguistic, and religious differences amongst groups of people (Nagel, 1994). Ethnicity in this thesis is discussed as a social construct, like the identity category of race (Gilroy, 2000; Nagel, 1994). It is therefore also understood to be fluid, dynamic, and situational. Ethnicity is identified, organised, and produced within negotiable boundaries and cultures, and through social interaction between communities (Nagel, 1994). Barth (1998) describes ethnicity as a status which is ascriptive in nature and functional in a stratified system, and states that the differential control of assets are maintained through special processes.

Many definitions of ethnicity highlight a shared culture amongst different ethnic groups, while other definitions emphasise the existence of cultural similarities and differences. Barth (1998) argued that the cultural features of an ethnic group may change in different environments and institutionalise different values in different groups based on individual values and ideas. Hutnik (1991) further emphasises Barth's view by contending that despite behavioural assimilation, groups may simultaneously maintain a strong sense of ethnic identity through markers such as clothing, language, and basic value orientations, even in those people from second and third generations of migrants. In this sense, ethnicity is viewed as a product of one's self-awareness of membership in one group along with an understanding of being different from others.

Some definitions in the literature focus on self-definition rather than cultural features or the existence of ethnic boundaries (Shibutani & Kwan, 1965). One's self-definition may be based on the importance of a psychological need or, as described by Nagel (1994), one may have the 'creative choice' to identify - for example, as British rather than of Indian heritage. Ethnicity has also been defined by an emphasis on its ascriptive nature, whereby the perception 'of

themselves' and 'by others' is considered. This incorporates the possibility of adopting certain features of the dominant group, while also maintaining certain aspects of an ethnic heritage (Hutnik, 1991; Barth, 1998). This social constructionist concept of ethnicity recognises ethnic identity as being both externalised through its relation to membership of a collective, and internalised, denoting the individualistic element (Jenkins, 2008). Mason (2000) concludes that ethnicity is therefore situational; people have different ethnic identities in different situations and these are determined by the distribution of desired resources and the desires of the people concerned. Mason's perspective (2000) reiterates Nagel's (1994) contested point that ethnic identification is a 'creative choice', as a person can decide to be identified as English, British, or European in certain situations, or as Nigerian, African, or Black when in contact with white people. Although it should be noted that, in this context, people do not have the 'creative choice' to determine how others respond to their identification claims.

This thesis therefore understands one's positionality with regards to ethnicity to be in relation to an 'other' at a given time and place, as stated in chapter two and in the discussion on race above. The term 'creative choice' therefore must be examined critically. Mason notes that these choices are often not free, since people's 'choices' can be constrained by the response and behaviours of others and will depend on the situation. For example, the growing ethnic diversity of the UK's population is evidence of its historic legacy as colonial empire-builders (Nagel, 1994). Yet, despite this long colonial history and more recent migrations in response to the free movement of people as part of the UK's membership in the EU, ethnicity, similarly to race, is often practiced as a binary in which a distinction is made between the dominant group and a plurality of other subordinate groups, based on dichotomous ethnic statuses - majority/minority - and through the

maintenance of boundaries (Hutnik, 1991; Brah, 1996; Barth, 1998). The dominant ethnicity here, that is, white British, is not accredited as an ethnicity but is instead taken for granted as the norm, while it simultaneously remains dominant. This in turn means that the minority ethnicities are constructed as 'other', thereby reinforcing social hierarchies.

Ethnic boundaries have been defined as the production of classification struggles and negotiations by actors situationally located in a social system, such actors can be people working at individual, collective or institutional levels, who are making strategic choices based on their different social contexts and depending on the social system (Wimmer, 2008). On one hand is the possible strategies of ethnic boundary-making of shifting boundaries through expansion, by establishing a new boundary and expanding the people included, and on the other end is through contraction, contracting the ethnic boundary to reduce those included. Wimmer (2008) explains that nation building is perhaps the most consequential form of boundary expansion, a strategy usually chosen by authorities of kingdoms and empires, an example of that is the broad category Brazilian which is a mix of the White, Brown and the Black racial categories. While on the other hand, boundary contraction is usually an attractive strategy for individuals and groups and is exemplified by the West Indies immigrants requesting to be referred to as Jamaicans rather than Blacks. Institutional order, hierarchy of power, and political network can be seen as three features of a social system that enable the existence of ethnic boundaries (Wimmer, 2008). By virtue of an imbalance in status, power, and resources, the subordinate members of society, otherwise known as ethnic minorities, are bound together by their common experiences of discrimination and social disadvantage (Hutnik, 1991).

3.1.4 Gendered Identities

This thesis takes a social constructionist approach to an understanding of identity and identity categories such as race and ethnicity, but also gender. Gender can be seen as an accomplishment, 'a display', 'a role enactment', 'an emerging feature of a social situation', a social construct, and a social position, to mention a few definitions from a social constructionist perspective (Garfinkel, 1967, p. 129; Goffman, 1979, p. 69; Udry, 1994, p. 561; West & Zimmerman, 1987, p. 126).

West and Zimmerman conceptualise gender as "a routine accomplishment embedded in everyday interaction" (1987, p. 127), meaning it is established in relation to others and through interaction rather than as a set of behaviours and mannerisms constructed through psychological, social, and cultural means. Lorber also encapsulated gender as "a process of social construction, a system of social stratification, and an institution that structures every aspect of our lives" (1994, p .5), meaning it is embedded in the family, the workplace, the state, and through the media. By this, Lorber meant that the work people do shapes their experiences, and consequently produces feelings, consciousness, relationships, and skills marked as feminine and masculine, which she terms the social construction of gender. There are action-based expectations and gender boundaries that accompany such gender markers, and accomplishment of these actions is applauded, whereas actions contrary to expectations are frowned upon, and in some cases and societies attract punishments and stigmatisation (Stier & Lewin-Epstein, 2000). This is an example of Adichie's (2014) view, about the gendered expectations/stigmatisation about girls being raised not to aspire to much or they will threaten the man (potential or actual husband).

Lorber (1994) asserts that gender is a socially constructed process which starts with the assignment of a sex category based on genitalia. Since genitalia are not conveniently displayable, a person's sex category must be displayed in other ways, such as by dressing, naming and other markers which earn one a gender status. This gender status is linked with social boundaries that are institutionally created and maintained through the rules that apply to the different gender categories (Lamont & Molnar, 2002). These gender rules structure the organisation of daily life which is maintained through the production and reproduction of tasks and activities in social human groups, including the division of labour, assigned responsibilities for children and dependent adults, and allocation of scarce resources (Lorber, 1994). What constitutes a scarce resource varies depending on the context of a particular society, but, in societies where women are held in lesser esteem than men such resources include those that are limited and valued, and are often about economic resources or resources that might enhance the economic status of the individual, such as education and job opportunities. The outcome is that once individuals are 'sexed' after birth, they go through a gendering processes to satisfy the expectations of society that impacts on the division of labour, kinship, sexual scripts, personalities, social control, ideology, and imagery (Lorber, 1994).

In society, gender is about differences and, as with every identity category, the concept has boundaries and rankings which operate in a structural and hierarchical society (Lorber, 1994). Social boundaries symbolise social difference and manifest inequality through access to, and distribution of, resources and opportunities (Lamont & Molnar, 2002). This desire to compare and evaluate social collective groups is usually aimed at achieving and maintaining superiority, especially when it leads to a positive evaluation of one's in-group membership against another's

out-group membership (Lamont & Molnar, 2002). Gender is therefore part of a stratified social system, in which one gender is viewed as normal and dominant, while the other gender is deviant and subordinate. This stratification is applied across a range of contexts, including occupation. Acker (1990), for example, argues that hierarchical organisations are important locations of male dominance, whereby men occupy the powerful organisational positions.

As with race and ethnicity, gender too is 'done' in relation to an 'other'. This means that an individual's lived experience of and opportunities at work are structured by that individual's multiple locations in relation to their gendered, racialised, and ethnic identities. For example, Ridgeway (1991) explained that when people acquire status as a result of being recognised as cognitively distinguished, this determines and influences their possession and position of power in a hierarchical order on society's social stratification system. Ridgeway (1991) countered Blau's (1977) assertion about the independent effect of an identity category on the relative status of a person by explaining that these status-valued characteristics are not encountered, nor do they affect a person's relative status independently, but rather incrementally affect relative status of the multiple identities of individuals. She further stated that no one is identified or encountered by their gender, as male or female, or by their race, as Black or white, but rather as Black male, white male, white female, or Black female, as well as other socially significant identity categories such as age, ethnicity, nationality.

Ridgeway (1991) also argued that cultural beliefs about identity categories impact on the perception of an individual's competence and capabilities, structuring the individual's acquired status in society. Based on this evaluation, Ridgeway (1991) argued that Black men and white women are accorded less status than white men, and Black women accorded less status white

women and Black men, and so are positioned at the bottom of society's hierarchy. It is therefore important when considering identities at work to develop an analysis that recognises some of the multiple positions an individual occupies, a standpoint that is central to intersectional analysis, to which I now turn.

3.2 Intersectionality and Identity

The feminist movements of the 19th and 20th centuries led to the actualisation of certain rights for women, such as suffrage and better access to public roles, education, reproductive rights and higher status employment. However, significant criticisms were directed towards these feminist movements, in terms of the way they maintained raced and classed privilege by normalising white, middle class, heterosexual women's experiences and needs (hooks, 1981; Brah & Phoenix, 2004). As part of this critique, those women who felt excluded from these feminist movements fought to establish equal opportunities for all women by campaigning for other excluded perspectives along the lines of class, sexuality, race, dis/abled bodyness (Crenshaw, 1991; McCall, 2005). What subsequently developed out of these developments in feminist activism was an 'intersectionality' theoretical framework.

Intersectionality was coined and conceptualised to highlight the distorting experiences of Black women's multidimensional identities through the single-axis analysis in feminist research that positions gender as central (Crenshaw, 1989). Crenshaw argued that a:

> *"single-axis framework erased Black women in the conceptualisation, identification, and remediation of race and gender discrimination by limiting inquiry to the experiences of otherwise-privileged members of the group"* (1989, p. 140).

Crenshaw examined the ways in which the courts framed and interpreted the stories of Black women and concluded with an analogy to traffic, in which discrimination, like traffic through an intersection, may flow in one direction, or in another, and that the occurrence of an accident at the intersection could be caused by cars from any number of direction or from all directions at once (Crenshaw, 1989). Through this analogy, Crenshaw argued that the injuries from an accident could be likened to the discrimination experienced by a Black woman at an intersection which could have resulted from discrimination similar to those felt by white women or to Black men, but often from double discrimination, the combined effect of practices against Black women, rather than the sum of race and sex discrimination.

The subject of discrimination occurring simultaneously as multiple identities interacted had already been discussed by several activists and scholars alike before Crenshaw's seminal paper. For example, the American author, feminist, and social activist bell hooks had posited the idea that women, particularly Black women, faced discrimination beyond their gender that determined their status and consequently their fate, while Hull, Bell-Scott and Smith (1982) argued for deconstruction of feminist analyses in their book entitled 'All the Women Are White and All the Blacks Are Men, But Some of Us Are Brave'. Brah and Phoenix (2004) also recognise the contribution of earlier women in articulating what might now be understood as an intersectional perspective, giving as an example enslaved woman Sojourner Truth's speech at the

1851 Women's Rights Convention in Akron, Ohio, where she asked the now-famous rhetorical question 'Ain't I a woman?'. Thus, building on these antecedents, and in response to the issues of Black women being excluded by middle class white women in the feminist movements of the 19th and 20th centuries, Crenshaw (1989) coined the generative term intersectionality and thus helped form a new field of scholarship.

Intersectionality has since been heralded as a primary analytical tool (Nash, 2008), a major paradigm of research for women's studies (McCall, 2005), one of the most important contributions to feminist scholarships and a scholarly buzzword (Davis, 2008). These differences have led to significant debates around the meaning of the term. Some have argued that intersectionality is a tool for analysis (Collins, 2016; Nash, 2008), a methodology (McCall, 2005), a theoretical framework (McCall, 2005; Nash, 2008), or just a reading strategy (Davis, 2008). To avoid some of the theoretical, political, and methodological murkiness that intersectionality became associated with during these debates, Nash (2008) encouraged an understanding of intersectionality as a more complex way of theorising identity and oppression.

From the standpoint of understanding intersectionality as a complex way of theorising identity and oppression, commonalities across multiple definitions of the term can be identified. Three definitions from leading proponents in the field define intersectionality as a "broadly useful way of mediating the tension between assertions of multiple identity and the ongoing necessity of group politics" (Crenshaw, 1991, p. 1296); "the relationships among multiple dimensions and modalities of social relations and subject formations" (McCall, 2005, p. 1771); and "a theoretical

perspective that insists on examining the multidimensionality of human experience" (Dill, 2002, p. 6). These definitions commonly refer to multiple locations of discrimination occurring simultaneously and intersecting at crossroads that lead to inequalities (Crenshaw, 1989), which as Phoenix and Pattynama (2006) argue, make visible the multiple positions that constitute everyday life as well as the power relations that are central to it. Phoenix and Pattynama (2006) argue that their understanding of intersectionality allows for a more flexible analysis that can align itself with participants' experiences, producing a data-driven analysis rather than a top down analysis driven by the theoretical framework. It is for this reason that the current thesis employs their perspective of intersectionality.

As well as defining intersectionality, another key debate in the field is around the lack of an intersectional methodology and the number of categories to include in an intersectional analysis (McCall, 2005; Nash, 2008; Shields, 2008). Key points in these debates have oriented around how multidimensional identity categories mirror the complexity of social life, and are therefore challenging in their demand for a unique methodology (McCall, 2005). Further, feminist scholars acknowledge that identity categories share similarities but are also different in how they are constructed in the social world (Acker, 2006; Anthias, 2012; Yuval-Davis 2006). The outcome of these debates suggest that researchers should flexibly identify their method (such as whether to use qualitative or quantitative methods) and number of categories to study based on what is most appropriate to their research question and what are the most salient identities that can reasonably be studied together. As will be discussed in more detail in chapter four, a phenomenological qualitative methodology was chosen for this thesis since it aligned with methods designed to facilitate in-depth analysis of individual experience. The categories chosen for the sample whose

experiences are to be explored were based on gender (female identified women) and a national identity (Nigerian) and professional status (nurse/doctor). Given the cultural studies approach to identity outlined above, this national identity might, for any individual, be associated with a range of multiple racialised, ethnic and migrant identities, the salience of which would be identified in the data, aligning the thesis with the 'bottom up' intersectional approach recommended by Phoenix and Pattynama (2006).

3.3 Coping Mechanisms

Living life as the 'other', a 'disadvantaged minority,' can be stressful and traumatic for some (Smith, 1985), and yet bearable for others. By 'disadvantaged minority', I refer to the ethnic minority population who are disadvantaged by immigration status, ethnicity, gender, and race. In a culturally diverse society such as the UK, the daily life experiences of minorities differ, particularly those of the 'visible minorities'. For example, the labour market experience of a Black African person in the UK will differ from that of a Black African American person in the US. In the politics of identity and difference, positionality is negotiated according to the social hierarchy on which people find themselves in every given society. Disadvantaged minorities react to, and sense the need to, devise and develop strategies to deal with challenges, especially identity-associated stressors, as they encounter structural, institutional, and systemic inequality in society.

The development of coping mechanisms is dependent on the individual assessment of individual experiences and circumstances (Lazarus and Folkman, 1984). Park and Folkman (1997) argue that the meaning making people attribute to stressful events and conditions in their lives aids

their adjustment to the stressful event or condition. In the next section, frameworks of stress and coping mechanisms relevant to this study will be discussed generally and in terms of how they relate to race and gender particularly. Specifically, the work of Lazarus and Folkman allows an exploration of stress and coping strategies employed in the particular contexts to which the current participants refer. A growing interest in stress, particularly work-related stress, sparked off a corresponding interest in theories on coping (Lazarus, 1993) as individuals sought coping strategies as a means of responding to stress.

While it has been established that Black people experience racism and women experience sexism, these dual experiences do not quite capture the experiences of Black women, who experience stressors associated with sexism and racism interacting simultaneously, hence the term 'gendered racism', coined by Essed (1991) to encapsulate the discrimination meted out to Black women at work.

Lazarus (1993) described the process of coping as the effective management of psychological stress through cognitive and behavioural efforts. Coping is also primarily understood as a response to emotion (Folkman & Lazarus, 1988). Coping has been theorised in diverse ways, which can be categorised into coping as a personality characteristic, a process, or a hierarchical style (Haan, 1969; Lazarus, 1966, 1993; Menninger, 1954; Park & Folkman, 1997; Valliant, 1977). In this thesis, I will be adopting Lazarus's (1993) process approach to coping, due to its recognition of contextual influences and variance in coping over time and across different stressful encounters, thus acknowledging change over time and mapping onto the context of this

study since, as has been shown above, the migrant experience is characterised by change and stressful encounters.

Coping as a process sees people employing cognitive and behavioural efforts in response to different stressful encounters which are dependent on the appraisal of the stressful event (Lazarus, 1993). Stressful situations could be a loss, whether physical, emotional or mental, but response to any stressful event or circumstance necessitates an appraisal of, and consequently a response to, the situation (Folkman, 1984). As a process, coping primarily involves the perception of a threat to one's self, and the consideration of an effective response to the stressful situation. The execution of the conceived response is recognised as coping with the situation in question (Carver, Scheier, & Weintraub, 1989). The initial evaluative stage of the coping process is known as the primary appraisal, where an assessment of the situation is carried out, and then classified as harmful, beneficial, threatening, or challenging (Utsey, Ponterotto, Reynolds, & Cancelli, 2000). The consideration of an effective response to the situation is known as the secondary appraisal, in which an individual evaluates the resources (physical, psychological, social, material and so on) which are available to them before responding to the stressful situation at hand (Folkman, 1984). However, response to any given situation can change from time to time (Lazarus, 1993).

Folkman (1984) asserted that the process approach to coping involves a relationship between the person and the environment, which can be bidirectional, with each affecting the other, and constantly changing (Folkman & Lazarus, 1988; Lazarus, 1993). The appraisal and classification

of a stressor will usually generate emotions, and consequently a reappraisal can occur if there is a change in the person-environment relationship (Folkman & Lazarus, 1988). There are two major strategies of coping conceptualised by Lazarus (1993), which are problem-focused and emotion-focused. When employing a problem-focused coping strategy, the individual seeks to manage the problem causing the stressful situation. In contrast, when adopting an emotion-focused strategy, the emotion causing the distress is regulated, meaning the individual responds in ways such as, 'it could have been worse than this', 'I am a stronger person for having gone through this' (Folkman, 1984).

While it is agreed that there are differential responses to stress (Folkman, 1984; Lazarus, 1993), Park and Folkman (1997) emphasise that meaning making is central to one's response in stressful and unwanted life experiences and events. Research has shown that racism and sexism can act as serious stressors (Ayres, Friedman & Leaper, 2009; Clark, Anderson, Clark & Williams, 1999) which can be harmful and cause psychological and physical ill health (Lewis, Mendenhall, Harwood & Hunt, 2013; Pieterse, Todd, Neville & Carter, 2012). Hence, meaning making is particularly relevant for considering how people respond to racism and sexism.

Racism is an everyday occurrence in the lives of African Americans (Ong, Fuller-Rowell & Burrow, 2009; Utsey, Ponterotto, Reynolds & Cancelli, 2000), and is thus considered a serious biopsychosocial stressor for these people (Clark et al., 1999; Hayward & Krause, 2015). The experience of racism amongst African Americans is associated with a range of stress-related illnesses and diseases such as high blood pressure, stroke, hypertension, depression, and cardiovascular disease (Clark et al., 1999; Din-Dzietham, Nembhard, Collins, & Davis, 2004;

Krieger & Sidney, 1996; Mays, Cochran, & Barnes, 2007). However, research has shown that people from ethnic minorities may employ cultural-based coping strategies amongst other forms of coping to buffer the effects of discrimination.

Sexism has also been identified as a stressor that has negative health outcomes on individuals (Ayres et al., 2009; Kaiser & Miller, 2004; Leaper & Brown, 2008; Swim, Hyers, Cohen & Ferguson, 2001). It is suggested that individual and situational factors can influence the response (that is, engagement or disengagement coping strategies) of the individual affected in a sexist situation (Ayres et al., 2009).

African American women experience racism and sexism, often referred to as 'double jeopardy', and their responses to these stressors are determined by contextual factors (Lewis, Mendenhall, Harwood & Hunt, 2013), such as cultural factors when responding to racism (Utsey, Adams & Bolden, 2000), and individual or situational factors in response to sexism (Ayres et al., 2009). The racial category 'Black' includes other groups such as African Caribbean and Black African people. However, the stress management of these Black population immigrant groups is under-researched (Hunter, 2008; Stephenson, 2004). Although all Black groups may have a historic commonality - African diaspora - their differential and unique historical immigration experiences may contribute to differential culture-based coping strategies.

Research has shown that African Americans employ culture-based coping strategies to cope with the stressor of racism in addition to emotion-focused and problem-focused coping strategies

(Utsey, Ponterotto, Reynolds & Cancelli, 2000). Such culture-specific coping strategies include seeking the counsel of the elderly, religiosity, faith and spirituality (Utsey, Adams & Bolden, 2000; Shorter-Gooden, 2004). Shorter-Gooden (2004) explained that African American women have differential responses to racism and sexism than African American men; they were found to be more passive, and to employ avoidant strategies in responding to racial discrimination more than they do with sexism (Utsey et al, 2000). Brondolo, Ver Halen, Pencille, Beatty and Contrada, (2009) explained that the use of differential coping strategies at different episodes of ethnicity-related maltreatment is dependent on the anticipation of potential exposure to that threat, and the timeframe of exposure as well as the reoccurrence of the episode. Brondolo et al. (2009) highlight this differential deployment of coping strategies by minority groups as challenging, since cognitive flexibility is required to implement coping strategies that are appropriate and effective at each time point of exposure.

Extant literature on the experiences of Black women and their coping strategies employed as a response to stressors focuses on African American women. There is much less research on the experiences of Black African women who have emigrated to the UK. This is a gap that this thesis will address by exploring the experiences of a different group of 'Black identities' as well as the coping strategies they adopt in stressful situations at work and home. By conceptualising the participants of this study as immigrants, visible minorities in the hierarchical UK labour market, and thus as 'Black identities' in what Fanon (1952) called a 'white world', coping as a process framework will be used to provide insight into the coping strategies devised by the participants in responding to any threats associated with their new identities, and other stressful encounters as gendered and raced immigrants in the UK.

3.4 Organisational Perspectives and Inequality Regimes

In chapters two and three, I introduced literature examining gender and race in the workplace with specific reference to the healthcare sector. For example, I pointed to the work of Healy and Oikelome (2007, 2011), who focus on gender, ethnicity and migration in the healthcare sector in the UK and US from a comparative perspective. In their later work especially, Healy and Oikelome (2007) emphasise the limitations of diversity management and its interventions at work such as training, mission statements and diversity action plans, as well as other actions focused on long-term cultural change within the organisation. They note that researchers have only been able to offer mixed evidence on the effectiveness of diversity initiatives. Scholars focusing on race and gender in organisations have pointed to systemic inequalities (Acker, 2006; Browne & Misra, 2003; Glauber, 2008). This includes the ways in which discourses of meritocracy disregard the power relations underlying definitions of merit as well as shaping outcomes (Sliwa & Johansson, 2014), and the ways opportunities are shaped by such as by different access to social (James, 2000) and human capital (James, 2000; Vallas, 2003), among other examples, as well as experiences of prejudices, discrimination, and racism at work (Arifeen & Gatrell, 2013; Cooke, Halford & Leonard, 2003; Harrison, 2004).

Few intersectional frameworks examine gender and race concerns in an integrated manner within the workplace and so allow the consideration of professional status as a third dimension. In my thesis, I build on Acker's (2006) inequality regimes, which were conceptualised as an intersectional analytical tool to consider the ways in which organising practices and processes maintain inequalities in the workplaces. Developed from a study into gender in Swedish banks in

the 1990s, Acker initially coined the term gender regime to describe "the internal structures, processes and beliefs that distribute women and men into different tasks and positions" (1994, p. 10). She later developed her work, taking an intersectional lens and considering the ways in which gender, race, and class, among other factors, shape employees' opportunities at work. The outcome, the inequality regimes framework, provides an analytical tool which distinguishes between five organising practices at work, all of which help maintain inequalities even in the most egalitarian of workplaces, according to Acker (2006). These five practices and processes include: (1) organising the general requirements of work, (2) organising class hierarchies, (3) recruitment and hiring, (4) wage setting and supervisory practices, and (5) informal interactions while 'doing the work' (2006, p. 450). Each of these dimensions emerged out of preceding research and has the capacity to form a starting point for an intersectional analysis in its own right.

I have already touched on the first dimension earlier in the thesis. The way we organise the general requirements of work includes the division of work into long time slots, and is based on an ideal worker who, usually mapping the image of a young, white, able-bodied male (Acker, 2006), can work long hours unencumbered by other responsibilities such as a child or elder care. This includes the way we work in eight hour shifts for example, but is particularly relevant for the healthcare sector where doctors and nurses are often required to commit to very long shifts (Sheward, Hunt, Hagen, MacLeod & Ball, 2005). The organisation of workplaces around the image of an ideal worker discriminates against women due to them being more likely to be responsible for child or elder care, and is particularly difficult for Nigerian migrants who are less likely to have family or alternative support networks in place in the UK (Reynolds, 2006), as

demonstrated by Jasso and Rosenzweig (1995), who found that economic migrants were outperformed economically by kinship migrants in the long-term due to a lack of family support.

The second dimension, class hierarchies, is also relevant in the healthcare sector, where women are more likely to be nurses than doctors (Jefferson, Bloor and Maynard, 2015), for example, while women and ethnic minorities are also less likely to be in high status positions (Priest, Esmail, Kline, Rao, Coghill, Williams, Norman & Norman, 2015), neither horizontally such as in high status specialisations like surgery (Riska, 2011) nor vertically as consultants, and specialist doctors. Interestingly, the latter applies even in female dominated professions such as nursing. Men, even when in the minority, are more likely to be promoted than women (Williams, 2013). Williams (1992, 2013) described as a 'glass escalator' effect, noting that men in feminised professions mostly face discrimination from outside the profession but that they "take their gender privilege with them when they enter predominantly female occupations" (2013, p. 263) and encounter preferential treatment with regards to recruitment and promotion.

Thirdly, recruitment and hiring practices discriminate against women, ethnic minorities and migrants in several ways. For example, women and ethnic minorities and those with migrant backgrounds are less likely to invited for interviews, as has been consistently shown by studies using CVs with similar content where only the name or photos were changed to identify the sex, race/ethnicity or migration background of a candidate (Hiemstra, Derous, Serlie & Born, 2012; Kaas & Manger, 2012). In addition, research such as Goldin and Rouse's (2000) study of symphony orchestra musicians has shown that women were more likely to be hired when interviews or auditions were conducted behind a screen.

Fourthly, wage and supervisory practices refers to the ways in which wage setting is frequently, on the one hand, a bureaucratic process which women and ethnic minorities are less likely to proactively initiate (Babcock, Laschever, Gerland & Small, 2003) and are penalised for initiating (Babcock & Laschever, 2009), while at the same time, there is often an element of discretion, which is prone to being biased - consciously or unconsciously - by supervisors (Acker, 2006). For example, Acker found that in her study of Swedish banks, pay differentials between men and women increased over time despite fixed wage agreements organised by the workplace union. Small discretionary bonus payments were awarded primarily to men, thus resulting in a rising pay gap over time.

Finally, the fifth dimension, informal interactions while doing the work, relates to decision-making and the allocation of work on the basis of underlying assumptions about one another. For example, women being placed into roles where emotional labour is more likely required (Acker, 2006). The extent to which inequality regimes are ingrained within an organisation is then related to processes of in/visibility and legitimacy as well as control and compliance. For example, in rigid bureaucracies, inequalities can appear legitimate and one form of control may be internalised. Acker's framework has been popular with those examining inequality in the workplace from a sociological perspective and its usage within organisation studies is on the rise. In my work, and in particular in the analytical chapters five, six and seven, I draw on inequality regimes to think about the ways in which the NHS, like other workplaces, is a space where inequalities are not only maintained but also perpetuated.

3.5 Conclusion

In chapters two and three, the subject matter of this thesis was introduced and reviewed, a research gap identified, and an appropriate underpinning theoretical framework to address this gap was explored. To address the concerns of the thesis, four conceptual frameworks were introduced and explored. From cultural studies, Hall's conceptualisation of the migrants' identities as one of a 'process of becoming' was discussed as a way to explore processes of identity in transition; from feminist and Black feminist scholarship, an intersectionality lens was found to be useful for the study of the multidimensionality of the participants' experiences; from organisational studies, Acker's inequality regimes have been identified for examining the practices and processes that produce and maintain experiences of inequality within organisations; and from psychology, Lazarus and Folkman's coping strategies for stress was discussed as a framework for developing the understanding of how the participants responded to the stressors caused by their experiences of living and working in the UK as Nigerian female migrant healthcare workers. These theoretical frameworks will be applied in interconnected ways to data collection and analysis.

The findings captured three superordinate themes: 1) The process of becoming; 2) Inequalities at work; and 3) Coping with threatened identities. Overall, this study reveals a layer of complexity in how training may or may not act as a route for migrants seeking to improve their status. In particular, it pointed to the way those seeking higher status professions may experience greater stressors, due to intersections of racialised and gendered positionality. The thesis also showed the value of an interdisciplinary and intersectional approach; and contributed to developing knowledge

of inequality regimes in the NHS; and increased analysis of Black migrant women's experiences in a context where their voices are often absent.

CHAPTER 4 METHODOLOGY AND METHOD

This chapter discusses the methodological approach employed in this study and provides a justification for the choice of research methods. After specifying the aims of the study, it introduces and locates the study within qualitative and feminist methodologies, arguing that a qualitative approach is needed, combined with an intersectional lens from a Black feminist perspective. It then discusses the choice to use the phenomenological method of IPA to research the participants' perspectives. Key principles of IPA are thereafter described in terms of phenomenology, hermeneutics and idiography. How this methodology was actualised in practice is discussed in a method section that includes information on the design, participants, method of data collection, procedure, ethical considerations, method of analysis, reflexivity and quality criteria by which an IPA study might be judged.

4.1 Aims of the Research Study

This study set out to explore the gendered and racialised experiences of female migrants from Nigeria working in the British healthcare sector, and the implications of professional status for mediating these experiences. The literature review suggested that both being female and being a visible minority structurally positions individuals into lower status employment in the labour market (Basran & Li, 1998; Massey & Sanchez, 2010; Smith & Mackintosh, 2007Suárez-Orozco, 2000). Furthermore, gendered identities and roles mean that, even when in paid employment, women have greater domestic responsibilities at home. These familial responsibilities may further reduce women's ability to take up higher status work and/or increase

the amount of overall work they do, as described in Hochschild's phrase 'the second shift' (Bertrand, 2010; Hochschild & Machung, 1989). To better understand how gendered and racialised identities work to produce such differences, the literature review pointed to the importance of taking an intersectional perspective, so that the interactional effects of multiple social category positions (such as Black, Nigerian, woman) can be studied. Intersectionality as a concept emerged from Black feminism and aims "to account for lived experience at neglected points of interest" (McCall, 2005, p. 1780). This standpoint is also supported by Stuart Hall's (1996c) cultural studies approach to identities which conceptualised migrants as experiencing a process of 'becoming' through multiple identities that might be enabled or limited by an individual's wider political, economic and socio-historical context.

Highlighting the ways in which visually different minorities typically acquire low status attributes when immigrating to the UK, the previous chapters also pointed towards the importance of researching the possible mediating effects of professional status. Focusing on the healthcare sector, the previous chapters outlined the need for further research to understand the processes involved in how commonalities and differences are experienced and interpreted by doctors and nurses. It was noted that extant research has particularly focused on the experiences of migrant nurses. However, little is known about relationships between groups of healthcare workers who differ in professional status, and how their experiences compare and differ from an intersectional perspective. To address this issue, this thesis employs an intersectional feminist lens to understand the experiences of a group of Nigerian migrant healthcare workers and how their professional status mediates that experience.

The research aims and objectives underpinned my philosophical and methodological stance as a researcher, and steered me in the direction of a qualitative phenomenological method. Qualitative methods focus on in-depth analysis of individuals' sense-making in context. Those studying individual lives from a phenomenological perspective focus on the analysis of people's experience and their interpretation of that experience. By combining the qualitative phenomenological method Interpretative Phenomenological Analysis (IPA) with a Black feminist perspective and an intersectional lens, this study sought to prioritise the voices of Nigerian women in order to understand their experiences as doctors or nurses working in the NHS. In so doing, it addressed a gap in the research about African women in the UK, examined new forms of gendered economic migration in the healthcare sector, and sought to develop intersectional research at the intersections of professional status as well as gendered and racialised identities in the healthcare context.

4.2 Feminist Intersectional Research

Feminists have challenged 'masculine' psychological and social science research in which men were constructed as the norm, and in which women's experiences were absent or devalued. The outcome was a range of feminist methods which sought to prioritise women's experiences and voices, which valued the study of women, and which contextualised women's experiences within their wider socio-historical context (Doucet & Mauthner, 2006; Oakley, 1981; Reinharz & Davidman, 1992; Stanley & Wise, 2013). Thus, despite a shared standpoint that problematised masculine approaches and prioritised women's voices, there is no single feminist method.

Rather, divergent feminist positions and debates have produced a range of methods, methodologies, and epistemologies. A key development in feminist thinking, described in chapter three, was the critique by Black feminists that second wave feminist work reproduced a white norm. Emerging from this work was the concept of intersectionality (Crenshaw, 1989).

The feminist approach taken in this thesis is intersectional. The argument for taking this approach is that while all feminists might consider themselves to share something in common related to 'experiences of oppression' because they are women, their experiences differ depending on how they make sense of, and are made sense of, in their social location through social categories other than gender (Stanley & Wise, 2013). Indeed, as argued in chapter three, an intersectional lens opens up the possibilities that, at any one moment, a woman's gendered identities may not be the most salient identities in her life.

In chapter three, I discussed the history and development of intersectionality as a theoretical framework. Here, I consider the methodology of intersectional research, in particular, the work of McCall (2005) and the implications of her typology of intersectional methods for the present thesis. The focus of intersectional research is on the "interaction of multiple identities and experience of exclusion and subordination" (Davis, 2008, p. 1464). However, how to identify which identities to study and how to go about that study in the context of the ambivalent nature and status of social categories is a significant challenge.

Addressing this challenge, McCall (2005) proposed three methodological approaches for the study of intersectionality: the intercategorical approach, the intracategorical approach and the

anticategorical approach. McCall (2005) defines these approaches in the following ways. The intercategorical approach adopts existing analytical categories to document relationships of inequality between social groups and changing configurations of inequality along multiple and conflicting dimensions. It is interested in the process through which the experience of a study's subject is lived and produced. In contrast, the intracategorical approach focuses on a single social group at a neglected point of intersection of multiple master categories or a particular social setting or ideological construction, or both. Finally, the anticategorical approach deconstructs analytical categories as well as normative assumptions of these categories. It challenges the constitution of categorisation.

Research Questions

1. How do gendered and racialised identities affect the experiences of female Nigerian healthcare migrants working in the NHS?

2. To what extent does professional status mediate their experiences of living and working in the UK?

To address the above research questions and aims of this thesis, the intercategorical approach was adopted since existing analytical categories (woman, Nigerian, migrant) were used to explore participants' experiences. While this approach is somewhat similar to the intracategorical approach, it differs because more than one group of women were under study (doctors and nurses), plus participants were grouped by the researcher using existing categories based on occupational titles.

The multiplicity of perspectives in feminist research allows for creativity in the choice of research methods, since feminism provides the perspective and the discipline and/or research question drives the research method (Reinharz & Davidman, 1992). Although important contemporary feminist work employs quantitative methods with positivist or post-positivist epistemological assumptions, these methods have been criticised by feminist scholars for their inadequacy in dealing with issues pertaining to voice and empowerment (Guba & Lincoln, 1994). Furthermore, positivist and post-positivist stances have been criticised for constructing such research as objective, rather than recognising the interpreted and socially produced nature of all research (Gray, 2014). Aligning with these critics, I decided to integrate the intercategorical approach to intersectionality chosen for the present study with a qualitative phenomenological methodology. As argued below, phenomenology provided an epistemological approach to the study of experience and interpretation of lived experience, which was central to the research questions (Smith et al., 2009).

4.3 Phenomenological Qualitative Research

Qualitative research is a method of inquiry that crosscuts disciplines, fields, and subject matters, utilising a variety of methods, approaches, and techniques in its inquiries (Denzin & Lincoln, 1994; Sullivan, Gibson & Riley, 2010). Qualitative research methods are particularly useful for the research questions posed in this thesis because they provide methods for analysing the meanings and interpretations used by people as they make sense of their experiences (Denzin & Lincoln, 1994). Understanding how people make sense of a phenomena through qualitative

methods can be contrasted with quantitative methods that focus on statistical differences between groups or cause-and-effect questions (Smith, 2015).

There are a range of interpretative qualitative approaches that seek to analyse how people make sense of an issue. Some of these take a social constructionist approach, focusing on how a phenomenon is produced in talk in ways that create a particular social reality at a particular time rather than the lived experience of meaning making. In contrast, phenomenological approaches aim to examine and capture the subjective perspective of lived experiences and how these experiences are interpreted by individuals (Denzin & Lincoln, 1994; Smith, 2015). Given the focus on the lived experience of the participants in this thesis, the phenomenological method of IPA was chosen.

4.4. Interpretative Phenomenological Analysis (IPA)

4.4.1 Critical Realism

IPA is based on a critical realist meta-theory (Smith, et al., 2009). The ontology of critical realism is that reality exists and has causal effects that can be studied; however, its epistemology is relativist. Epistemology refers to the ways in which the nature of knowledge and the justification for the belief in such knowledge is constructed (Ramazanoglu & Holland, 2002). Critical realism has been heralded as an alternative to both post/positivism and social constructionist approaches (Sayer, 2004) because, while it recognises the relativist nature of knowledge, thereby acknowledging the production of knowledge to be subjective, it also considers reality to exist outside of the subjective and allows for the possibility that causal

mechanisms can be accurately identified (Guba & Lincoln, 1994). Critical realist philosophy also understands 'reality' as occurring at several levels. These include the materially real (such as rivers, mountains, planets), ideally real (for example, discourses that circulate in society such as the idea of migrants being low status), socially real (these include class and gender social structures), and artificially real (such as roads or buildings). This allows the critical realist researcher to understand socially constructed constructs such as gender to have real effects.

The outcome is that critical realist researchers seek to understand the phenomenon under study as objectively as possible, while recognising that the researcher's access to reality is never direct and so only partial. In order for researchers using IPA to try to understand experience and interpretation of experiences, its critical realist meta-theory thus frames the aims of the method as being to understand the respondents' experiences as closely as possible, treating experience as real in terms of having causal mechanisms and real effects, while always knowing that their analysis can only ever be an interpretation.

There are significant debates in philosophy of science on critical realism. However, while IPA is underpinned by critical realism, researchers using this method tend to focus less on debates around critical realism and more on locating their critical realist standpoint within three founding principles of IPA: phenomenology, hermeneutics and idiography.

4.4.2 Phenomenology, Hermeneutics and Idiography of IPA

IPA is a qualitative research method that was originated and developed in psychology. However, its applicability goes beyond the discipline of psychology and into other disciplines interested in experience (Smith et al., 2009). As an experiential approach to qualitative research, it commits to exploration, description, and interpretation of how a 'particular' experiential phenomenon is understood from a 'particular' social location, in a 'particular' context (Smith et al., 2009). Its focus on experience locates IPA within phenomenology, since amid the variant philosophical views of that discipline, phenomenologists have maintained that experience be the starting point of any research investigation (Ashworth, 2015). Phenomenologists argue that understanding experience is centred on understanding the perception and sense people make of their world, and the meaning attached to the experience (Giorgi & Giorgi, 2008; Langdridge, 2007; Smith et al., 2009).

This standpoint draws, in particular, on the work of philosophers Husserl and Heidegger. From Husserl, IPA emphasises the importance of trying to understand the essence of an experience of any given phenomenon, based on Husserl's argument that a person's experience is their fundamental source of knowledge (Racher & Robinson, 2003). In Husserl's phenomenological formulations of the everyday lived experience, meaning is prioritised by obtaining an insider's perspective through a process of interpretative activities (Langdridge, 2007; Smith & Osborn, 2015; Todres & Wheeler, 2001). The originating idea by Husserl was for the adoption of a phenomenological attitude directed inwards towards our perception and conscious reflection of things rather than merely thinking of the activities, so that the core structures and features of human experience could be identified (Langdridge, 2007; Smith et al., 2009). From this

standpoint, commonalities can be identified across similar individuals, such as those who are similarly positioned across social categories, as with the respondents in the present study. Husserl also influenced IPA researchers to consider that the consciously accessible knowledge of individuals is valuable information, so that the focus is on "the process occurring in consciousness and the object of attention for that process" (Smith et al., 2009, p.13).

Drawing from the work of Heidegger, IPA is also based on the principles of hermeneutics. Hermeneutics is the theory of interpretation (Smith et al., 2009). While there are various hermeneutic theorists, the formulations of Heidegger were seen as important for unpacking the component elements involved in phenomenology in order to develop the interpretative extraction of meaning (Langdridge, 2007; Smith et al., 2009). The most important contribution from hermeneutics is the idea that IPA researchers should facilitate reflection in the participants, so that part of the researcher's work is not only to understand the participants' experiences better, but to facilitate in the participant a better understanding of their experiences, which is then also information for the researcher. By drawing on Heidegger's idea of hermeneutics, IPA researchers thus seek to access more than what was already consciously known.

Through the philosophies of Husserl and Heidegger, IPA researchers also argue for the value of existing knowledge, so that the work of the IPA researcher is to facilitate drawing on both the participant and the researcher's knowledge and past experiences to develop new ways of understanding the phenomenon in question. This new interpretation will be of use to both researcher and the participant. At the hermeneutic stage, the researcher takes an active role in

attempting to make sense of the participant's experience as the participant is trying to make sense of their experience. This is known as a double hermeneutic in IPA studies (Smith, 2008; Smith et al., 2009; Smith & Osborn, 2015). This interpretation is achievable through the acquisition of certain skills (see section 4.8 below for examples, such as bracketing) and the researcher sharing some common ground with the participant (Schleiermacher, 1998; Smith et al., 2009). The concept of bracketing involves the temporary suspension of any pre-understanding and critical judgement a researcher brings into the mean-making of a participants' experience, based on the researcher's own assumptions and experience (Husserl, 1999). I have included paper trail evidence of bracketing for the purposes of transparency, validity and trustworthiness of the research process and research findings.

In an IPA study, the researcher not only employs the same mental and personal skills and capacities as the participant, although more self-consciously and systematically than the participant, but shares the fundamental property of being human with the participant as well (Smith & Osborn, 2008; Smith et al., 2009). This process of interpretation of the participant's experience leads to the idiographic element of an IPA study.

Idiography is the third important theoretical underpinning of IPA. Idiography is an approach that examines details of how particular individuals understand particular events (Smith & Osborn, 2015). Idiography endeavours to make sense of the experience of the individual's cognitive, linguistic, affective, and physical being (Drummond, Hendry, McLafferty & Pringle, 2011). In practice, idiography in IPA involves the detailed examination of individual cases, until a degree of closure for the case in question has been achieved. At this point, the researcher moves on to

the next case (Smith, 2004). IPA is strongly idiographic in nature and involves the study of the uniqueness of people and their experiences, thus allowing for individual differences (Ashworth, 2008). Due to the idiographic nature of IPA, studies intentionally comprise small sample sizes to ensure a detailed, nuanced analysis of data (Smith & Osborn, 2003). However, this study developed and utilised some novel processes.

Developments in IPA

As IPA is idiographic in its approach, the question of homogeneity required by IPA research comes into play. During my research study, I looked at the data set as a whole, but then explored it for any similarities and differences between the two professional groups, doctors and nurses, particularly in how they talked about their experiences. Furthermore, as soon as I concluded the IPA analytic process, I gave it a conceptual twist.

Also, there are a number of research papers that have conducted comparative IPA studies recently. In the study by Stuart-Smith, Smith, and Scott (2011), a comparative study was conducted whereby the women-participants were divided into two groups of women - those who were childless, and those with a genetically related child or children. For the other comparative IPA research studies, see Dean, Smith, Wayne, and Weinman (2005), where nine (9) low back pain patients and eight (8) physiotherapists were interviewed and in Rostill-Brookes, Larkin, Toms, and Churchman, (2010) IPA study the sample size was divided into four triads of young people, foster carers and social workers. This examples thus highlights comparative research as a novel development of IPA to allow deeper analysis and also bringing together the IPA of psychology with a more conceptual /theoretical approach of gender research in organisational studies.

In sum, IPA is underpinned by valuing the study of experience, seeking to develop, interpret and identify the experiences of individuals, but also to identify the similarities and differences within and between individual cases (Smith & Osborn, 2015). At IPA's heart is the aim of producing an in-depth analysis of contextualised, interpreted experience, which makes it the method that best aligns with the research questions and aims of this thesis. Having outlined the methodology of this thesis, in the following sections I describe how the principles of a feminist intersectional IPA research were put into practice.

4.5 Method

A researcher establishes their ontological perspective through a set of theoretical framework(s), and their epistemological position through the philosophy underpinning their theoretical framework(s), and then, through their choice of methodology and methods, strategically manages research data that answer the research problems (Denzin & Lincoln, 1994). In this chapter, the critical realist meta-theory in which IPA is located, which accounts for the ontological and epistemological standpoint of this thesis, is addressed above. Following on from this, the aims of the thesis are to identify the experiences of Nigerian women working in the NHS as either doctors or nurses, and how they interpret those experiences. Below, the methods employed to meet these aims will be outlined, and in so doing will map out the logic and strategy for integrating the different components of this study to answer the research problem.

4.5.1 Research Design

This study adopted a qualitative psychology approach (IPA) to explore, describe and interpret the experiences of Nigerian migrant healthcare workers, focusing on the implication of professional status on their experiences. The design was an in-depth interview study performed in two phases with Nigerian nurses and doctors working in the NHS, UK.

Phase 1

The first phase of data collection involved 24 participants from different locations in the UK. These participants were interviewed face-to-face, starting with a few introductory questions that were asked to break the ice during the first few minutes and also to know a little bit more about the participants, these was followed by an unstructured, non-directive interview method. This method was used in the place of a set of standardised questions and involved the use of a set of cards with single words printed on each card, with view to the participants choosing cards relating to topics that they wanted to talk about. The discussion of the interview in this section is in relation to the procedure, however, the rationale behind the interview process is given below in section 4.5.4. The objective of using this card-choosing, unstructured interview method was to make sense of the everyday lived experience of the phenomena for the participants', by flexibly exploring the 'unanticipated' and 'unexpected' elements of their personal and social world (Smith et al., 2009; Smith & Osborn, 2015). At this point, the cards were laid out on the table and, with the audio recorder on, participants were invited to discuss any of the topics on the cards that resonated for them. Furthermore, this interview method was utilised to gain a better understanding of participants' individual migration experiences through a non-hierarchical, feminist relationship in these interviews which involved a female interviewer and female

interviewees (Oakley, 1981). The data collected was then analysed using IPA, and from this preliminary analysis, I made a decision to carry out a second phase of semi-structured interview to gain in-depth knowledge on emerging themes.

Phase 2

In phase two, following the establishment of rapport and trust with the participants in the first phase of study, eight of the initial 24 participants (four nurses and four doctors) were purposively selected and interviewed using Skype, a Voice over Internet Protocol (VoIP) technology. A semi-structured interview method was used to elicit information from participants using open-ended questions, allowing for discussion while still maintaining a non-hierarchical relationship. This complimentary data collection tool was ideal to use in a time-efficient and financially affordable manner, as it eliminated traveling around the UK as well as the associated costs. A purposive/convenience sampling ensured a selection of available participants who could provide in-depth information on the emerging themes identified from phase one, and give clarification on their responses in the first interview. The data collected in the phase two interview was again analysed using IPA, and then the analyses of both data sets were brought together in order to identify similarities and differences across and within the two groups (doctors and nurses). This two-phase design was a novel development adopted for this IPA project, and was developed to allow the in-depth engagement with participants' interpretation of their experiences that is the hallmark of quality for IPA research.

4.5.2 Participants

The participants in this study were Nigerian migrant women purposively selected in line with the qualitative paradigm and IPA approach (Smith et al., 2009). These participants were first generation immigrant Nigerian women working as either doctors or nurses in the NHS, UK. The selection of only first-generation, rather than second-generation, immigrants for this study was based on the variances in migration experiences and outcomes between the two generations due to the differences in rates of assimilation and integration (Algan, Dustmann & Glitz, 2010; Levitt & Waters, 2002).

The recruitment of 12 doctors and 12 nurses was for comparative purposes, to explore the intersections of gender, racialised identities and the mediating role of professional status. While conducting comparative studies in IPA research studies may not be common practice, Jonathan A Smith, the pioneer of IPA, indicated via personal communication (email) that the use of comparative studies in IPA is gradually becoming common practice (see appendix C for email). Furthermore, Smith and colleagues (2009) stated the need for IPA researchers to use a fairly and reasonably homogenous sample, and emphasised that the extent of homogeneity may vary from study to study.

Additionally, it was necessary to split the sample group of healthcare professionals into two – nurses and doctors – so that the role of professional status could be understood from more than one perspective (Smith et al., 2009). It was to understand the role of professional status from the different positions they occupy, and to examine the similarities and differences within and between the groups in great detail. While also recognising that it was important to see if

professional status would mediate these experiences, this was justified in the findings. The findings showed a shared experience of racism at work, limiting their opportunities for progression, but their responding strategies differed depending on their professional status. For example, the doctors used geographical mobility as a coping strategy and the nurses did not. Again, the findings in chapter 5 and 6 both showed mostly shared experiences, despite differences in professional status, further supporting the justification to bring them together as migrant Nigerian women working as health care providers in the NHS.

This number is slightly higher than traditional IPA, which often has sample sizes of 10 or less, in part so that analysis does not become less in-depth due to researchers being overwhelmed with large data sets. However, since the thesis was a large research project, with the time to dedicate to in-depth analysis, and as it involved a comparison, the decision was made to recruit more participants than in a traditional IPA single group study.

My insider status meant that I was aware that it is highly sensitive and socially unacceptable to ask a lady her age in Nigeria. Therefore, I respected participants' privacy in that regards. However, these women were of working age (16 to 64 years) and in active employment in the NHS, and had been in the UK between five and 34 years. All except three were married at the time of the first interview, but by the second interview, one of those three participants had got married. All but two of the participants were mothers. Participants were recruited from across the UK, particularly from London, as London has the largest Black population in the UK (Reynolds, 2001). Participants also came from other cities, as well as regions and rural areas of Wales and Scotland, and so represented a good range of experience from across the NHS. Inclusion and exclusion criteria are discussed below.

Participants were chosen for their homogeneity, which is important for IPA (Smith et al., 2009). And in line with the intracategorical approach to intersectionality taken by this thesis, in which existing analytical categories are used (McCall, 2005), the socio-demographic categories considered for the homogeneity of the participants was their sex (female) and nationality (Nigerian). In addition, the following inclusion criteria were used:

1. The length of residence in the UK

   This was an important inclusion criterion. Participants were sought who were able to talk about a range of work-related experiences, including early migration experiences and entering into the workforce, as well working in the NHS as an established member of staff and relatively settled immigrant. Length of residence in the UK was initially set at 10 years or more, but when recruitment proved difficult, this was reduced to five years or more. The interviews resulted in a wide range of experiences described.
2. First generation immigrants living in the UK
3. Healthcare workers employed in the NHS (doctors or nurses)

Exclusion criteria were:

1. Nigerian women working in healthcare occupations other than medicine and nursing
2. Nigerian women who were second-generation immigrants in the UK

The selection criteria therefore included length of residency, migrant status, professional status, location of employment, gender, and nationality. However, emigrating as a healthcare

professional was not an inclusion criterion, thus allowing participants who retrained in the UK into the healthcare sector to be recruited. Demographics of the participants can be found in table 4.1 below.

Participant (pseudonyms)	Marital status at 1st interview	Length of residence in the UK	Migrant status at entry	Career in Nigeria	Occupation in the UK	Level of qualification from Nigeria	Professional Specialty
Anne	Married	9 years	Economic	Medicine	Medicine	Graduate - Level 6	GP
Beverley	Married	9 years	Economic	Medicine	Medicine	Graduate - Level 6	GP
Cathryn	Married	11 years	Marriage-related	Psychology	Nursing	Graduate - Level 6	Nursing
Davina	Married	21 years	British citizen	Medicine	Medicine	Undergraduate	GP
Eileen	Married	14 years	British citizen	College graduate	Nursing	Undergraduate	Nursing
Flora	Married	10+ years	Student	Nursing	Nursing	Postgraduate - Level 7	Nursing
Gail	Married	7+ years	Marriage-related	Nursing	Nursing	Diploma - Level 4	Nursing
Helen	Married	14 years	Marriage-related	Banking	Nursing	Graduate - Level 6	Nursing
Irene	Married	10+ years	Student	Aviation	Nursing	Postgraduate - Level 7	Nursing
Jennifer	Married	12 years	British citizen	Medicine	Medicine	Graduate - Level 6	GP
Karen	Married	10+ years	Marriage-related	Medicine	Medicine	Graduate - Level 6	GP
Linda	Married	5+years	Student	Business administration	Nursing	Graduate - Level 6	Neurology
Mary	Single	13 years	Economic	Medicine	Medicine	Graduate - Level 6	Psychiatric
Nina	Married	10 years	Economic	Accountancy		Undergraduate	Nursing
Olivia	Married	5 years	Marriage-related	Medicine	Medicine	Graduate - Level 6	GP
Pippa	Married	10+ years	Marriage-related	Medicine	Medicine	Postgraduate - Level 7	Medicine
Quincy	Married	28 years	Marriage-related	Medicine	Medicine	Graduate - Level 6	GP
Rose	Married	5+ years	Marriage-related	Medicine	Medicine	Graduate - Level 6	Paediatric
Sharon	Married	10 years	Student	Business administration	Nursing	Graduate - Level 6	Nursing
Tracy	Single	32 years	British citizen	Business & finance	Nursing	Graduate - Level 6	Nursing
Ursula	Single	25+ years	Visitor	Biochemistry	Nursing	Graduate - Level 6	Nursing

Vicky	Married	15 years	Marriage-related	Business administration	Nursing	Postgraduate - Level 7	Nursing
Winnie	Married	15+ years	Marriage-related	Business administration	Medicine	Graduate - Level 6	GP
Xara	Married	20+ years	Child dependant	Secondary education	Medicine	Graduate - Level 6	GP

Table 4.1 Participant demographics

*Length of residence in the UK – based on calculations from participant's first entry/return into the UK

*Level of UK educational qualification (equivalent)

4.5.3 Recruitment Strategy

The effectiveness of a recruitment strategy is dependent on certain factors, including the demographics of the sampling population (Yancey, Ortega & Kumanyika, 2006), cost and time (Patrick, Pruchno & Rose, 1998). Snowballing is a popular recruiting technique that involves contact tracing, whereby established contacts source others who meet the criteria and have the desired characteristics (Sadler, Lee, Lim & Fullerton, 2010). Snowballing was designed as a recruitment strategy to help overcome challenges associated with the recruitment of difficult-to-reach groups (Sadler et al., 2010) and was employed for this thesis, along with other techniques, such as approaching professional bodies, churches, using personal contacts and through social networking. The snowballing technique was adopted after the first contacts with participants were made; these participants introduced other contacts of theirs who matched the criteria and desired characteristics. This multi-level and mostly informal recruitment strategy was deemed a suitable technique, particularly since I, as a cultural insider, was able to adapt interactions (Yancey, Ortega & Kumanyika, 2006). Recruiting participants from minority cultural and ethnic backgrounds is often time-consuming and costly (Ibrahim & Sidani, 2014), and this study was no different; while the multi-level approach was effective for recruitment, significant time, effort and creativity was needed for identifying potential participants.

Recruitment was a challenge for a variety of reasons specific to this project, as well as the already documented difficulties of recruiting from minority groups (Ibrahim & Sidani, 2014). For example, the women approached often had traditional gender roles at home that coupled with paid employment, meaning they worked for long hours and had little spare time to dedicate to an

interview. This affected both the ability to recruit easily and scheduling time- and location-convenient appointments for both the myself and the interviewees. In addition, some potential participants were contacted who did not follow up on the appointment-scheduling calls/texts.

Attempts to recruit through more formal organisations, be they religious (since Nigerian people are religion-centred) or professional proved futile. For example, recruitment through online contact with the professional body Medical Association of Nigerians Across Great Britain (MANSAG) was unproductive. It is difficult to say why these approaches did not work, but I surmise it may be, in part, due to the very busy lifestyle of this group. Overall, informal recruitment strategies were more successful, because perhaps they gave me direct access to Nigerian women working as doctors/nurses who thought the project was important or who appreciated the opportunity to tell their experiences.

My recruitment challenges meant that recruitment took longer than anticipated. They also meant that, for phase one of the research, I went to wherever there was a participant available, meaning I travelled to different parts of the UK and interviewed participants in places of convenience to them, which included their homes, as well as public places such as their workplace or a nearby café. While this meant a meaningful amount of time and financial resources were spent in travel and recruitment, the geographical dispersal of the participants proved beneficial to the project because it both allowed me access to the different experiences their different geographical location afforded these women in this study.

4.5.4 Data Collection

The primary method of data collection for this thesis was the interview. Two types of interview were used. In phase one, a novel, relatively unstructured interview technique was used in which participants were offered a range of words deemed relevant to the study that were printed on cards, and participants were invited to pick a card and discuss its topic in relation to their experiences. In phase two, a more traditional semi-structured interview technique was used to explore in more detail key findings of the preliminary analysis of phase one. Below, I outline the principles and practice of these interview styles.

A research interview is a systematic form of social inquiry in which the collection of data is verbatim. Interviews enjoy a high status amongst qualitative methods of data collection (Holliday, 2002). They are a common data collection technique in qualitative research (Holliday, 2002; Smith & Osborn, 2015; Willig, 2001). Not only are interviews familiar, they are also considered legitimate avenues of generating information that seek to understand people's lives (Hugh-Jones, 2010). In-depth interviews invite participants to offer a detailed first-person account of their experiences and the target phenomenon (Smith et al., 2009). This first-person approach is enabled because one interviewer speaks to one participant at a time to obtain a subjective account of their experiences, in contrast to focus groups that involve several participants being the focus of the interview (Hugh-Jones, 2010). The choice of interviews over other methods for this study was in line with IPA's idiographic approach as well as the research questions, which directed attention to personal experience. The idiographic approach was also enabled through the use of relatively unstructured as well as semi-structured interviews, allowing

me the opportunity to modify initial questions in relation to the participants' responses, as well as allowing the participants to have agency in directing the content of the interview, especially during the first phase (Smith et al., 2009).

As discussed above, the aim of IPA is to understand the individual experience through deep attention to rich qualitative data. However, IPA research is dominated by a single interview design, limiting the amount of rich data gained from any one individual (Smith et al., 2009). To address this issue, a more innovative design was employed, in which two forms of interview data were collected. In phase one, relatively unstructured interviews were undertaken, and in phase two semi-structured interviews were conducted based on the analysis of phase one data.

In phase one, a relatively unstructured 'card-choosing' interview was used, in which participants were invited to discuss as many or as few topics offered to them by the researcher (more details on this can be seen below). The nature of unstructured interviews is open-ended and "implements IPA inductive epistemology to the fullest" (Smith et al., 2009, p. 70). This approach facilitates a participant-defined interaction, giving the participant a sense of agency since the selection of topic is a shared responsibility between the interviewer and interviewee (Smith et al., 2009). The choice to pursue a relatively unstructured first interview was underpinned by the feminist principles of the study, which sought to create non-hierarchical research (Oakley, 1981; Oakley, 1998) and thereby prioritise the voices of Nigerian women in order to understand their experiences as doctors or nurses working in the NHS. Adopting a relatively unstructured

interview was also done to reduce power imbalances between the interviewer and the interviewee (Corbin and Morse, 2003).

Phase one's relatively unstructured interview commenced with introductory questions to establish rapport with the participant (such as 'Can you tell a bit about how you came to the UK?'). These introductory questions were followed by a card system, in which I laid out a set of flashcards with single words on each that related to the research topic. For example, cards included words such as 'woman', 'work', or 'migration'. The words were developed by compiling a list of issues that emerged from the literature review on topics relating to Nigerian women's experiences of migration and work in the healthcare sector in the UK. In total, 38 cards were produced, and spread out on a table so they were all exposed, to allow the participants make a choice. There were also blank cards to allow participants to introduce topics they considered relevant but that were not already on the cards (see Appendix D for a full list of words), religion was one predominant topic discussed through the blank card option, with a participant expressing surprise that 'religion' was not included.

Once all the cards were presented on the table, participants were invited to pick a card to talk about. They could pick as many or as few cards as they wanted, and talk about the topic in the way they wanted. This ensured that participants were given a degree of agency to drive the structure of the interview, while also being given support to do so. Creating this level of agency was considered an important mechanism for getting as close to the participants' experiences as possible. This 'card choosing' method is a new addition to the qualitative interview and was developed by Robson (2017) to enable participant-driven and supported interviewing. It was

successful for the present study. The participants appeared to like the idea of a card, as they chose and talked about each subject at will. Different participants talked about the same card in different ways, suggesting its value over a fully formed question on the topic that might have been experienced as more directive. Most participants chose and talked about their migration experience, which was contrary to my expectation. From my personal experience, Nigerians are known to be very private especially around issues of migration. The interview finished when participants said they had exhausted the cards they wanted to talk about, and was completed with my asking if they had anything else to add about their experiences of being Nigerian women working in the UK's NHS.

In contrast, the second-phase interview employed a more traditional semi-structured interview schedule. This interview was conducted following the analysis of the first-stage interview, seeking to 'dig deeper' into emerging themes to get a better understanding of the experiences of the participants. This approach was in line with the contemporary understanding of interviews as co-constructive and relying on the interaction between the interviewer and the interviewee, thus co-producing more data (Hugh-Jones, 2010). The semi-structured interview involved going through an interview schedule with each participant (Hugh-Jones, 2010). Semi-structured interviews are popular as they are good for structuring conversation around what both the researcher and participant think are important; they were valuable here because the preliminary work had been done (Langdridge, 2007; Smith, 2015). As the main issues were identified in the first-phase interview, the second-phase was a deliberate attempt at a more focused conversation on these issues, which required a more structured but also open interview method, for which the semi-structured interview was the perfect fit.

4.5.5 Ethical Considerations

I sought ethical approval from the Institute of Human Sciences Ethics Committee at Aberystwyth University, that operated in line the British Psychological Society's Code of Ethics and Conduct (BPS Code) for conducting research with 'healthy participants' aged 18 or over. The ethics form was approved after I addressed some risk assessment issues around lone working. The key issues regarding ethical issues for the participants were: providing clear information so that participants could give informed consent; not creating a situation in which participants felt like they have to disclose more information than they might want to; taking care of participants' emotional needs if they became distressed while discussing unhappy experiences; clearly explaining how the interview data would be made anonymous and that personal information would be kept confidential; explaining when participants could withdraw from participation or their data from the study; and explaining how data would be stored safely. For example, given that some participants took jobs in the regions where they might be the only Black female doctor, geographical location information was limited to country.

The key risk assessment issues for the researcher were identified as hazards relevant to lone working, based on Aberystwyth University lone worker policy, which included:

1. Transportation to and from home by public transport
2. Violence/assault by participant or other members of participant's household
3. Attack by animals, particularly dogs.

Issues with transportation and violence were considered low risk given that participants were recruited through social recommendations. In addition, I took the precaution of ensuring I had network coverage by having two mobile phones with different networks, and contacting my supervisor before and after every interview, as well as providing my geographic location to my supervisor for my safety. See Appendix E for more details on how I assessed these risks and provided control measures considered in line with the Health and Safety at Work Act 1974 (HSW Act) and the Management of Health and Safety at Work (MHSW) Regulations 1999.

4.5.6 Procedure

After initial recruitment activities which involved contacting the potential participant, explaining the study and inviting them to participate, those who wanted to participate agreed a date and time to be interviewed and were sent the participant information sheet. Participants were then interviewed at a time and place convenient to them, according to the one-word-card choosing style interview technique described above. The interview started with a verbal description of the study and participants were then given the participant information sheet to read again (see Appendix K). They were given the opportunity to ask questions, and were reminded of their right to withdraw from the study at any time, and to have all or part of their interview data deleted up to the date when the analysis would be completed. They were then asked to sign a consent form (see Appendix L).

At this point, the cards were laid out on the table and, with the audio recorder on, participants were invited to discuss any of the topics on the cards that resonated for them. Follow-up

questions were asked, with view to developing participants' accounts and thus accessing in-depth data about their experiences and interpretations of those experiences. At the end of the interview, participants were asked if they had anything else to say and thanked for their time. A copy of their consent form and participant information sheet was left with them.

Interviews were then analysed using IPA (see section 4.6). Key themes from the IPA analysis were used to develop a semi-structured interview schedule. The 24 participants were then contacted to see if any were interested in taking part in a follow-up interview. Twenty-two participants were still contactable, and of these, eight participants agreed (four nurses and four doctors), who then participated in the second interview. Since rapport had already been developed with many of the participants through phase one of the study, and emerging research suggests that interviews over the medium of online video calls have been successful (Bertrand & Bourdeau, 2010; Broekhuizen & Evans, 2016; Hanna, 2012), phase two interviews were conducted via Skype. They followed a similar pattern, with participants being reminded of their rights and the rationale of the interview and wider study. Participants were then asked to review the participant information sheet and sign a consent form before the interview was arranged on Skype. In line with semi-structured interview practice, participants were asked a series of pre-planned questions with prompts developed during the interview to facilitate the participant in describing in as much detail as possible their experiences and interpretations of those experiences. All interviews were audio recorded to allow the interviewer to capture the talk and allow for in-depth analysis of how participants described their experiences and the nuances in their talk (Smith & Osborn, 2015). The audio recording was consented to by the interviewees and allowed the smooth running of the interview since notes were not taken and the researcher

could focus their attention on listening and responding to the participant. Transcription of the audio-recorded interview followed the playscript format, for the transcription notation (see appendix A), which included all the words spoken, including false starts, significant pauses, laughs and all other features worth recording. The transcription concluded the data collection phase.

4.6 Data Analysis

At the analytical stage, attention was paid to the interpretative, hermeneutic, and idiographic activities involved in an IPA study in order to facilitate the understanding of human experience (Shaw, 2010). Since IPA is a critical realist method, it seeks to understand by gaining access to the reality that exists in a particular context, through the researcher's interpretation of the participant's own interpretation (Smith et al., 2009; Shaw, 2010). IPA is a method that involves several prescriptive analytic steps in analysis. These are outlined below.

Step 1: Reading and Re-reading

The transcripts were read and re-read to immerse myself in the original data, and familiarise myself with the transcript and engage with the data, and on some occasions the audio recording was re-listened to for full engagement with the data. In engaging and re-engaging with the data, overt attempts were made to bracket off any preconceptions and thus engage with the participants' experiences from their perspective.

Step 2: Initial Noting

This stage of analysis was quite time consuming, and most detailed of all the steps involved in analysing IPA data. This step is the exploratory note-taking step, and note-taking was descriptive, linguistic and conceptual, and involved the development of legible comments. At this stage I moved from being descriptive (describing key objects of concern that mattered to the participant, such as relationships, processes, places, and so on), staying close to the participant's explicit meaning (Smith, Flowers, & Larkin, 2009). Note taking was also linguistic, and looked at the embedded meanings of metaphors, pronoun use, repetition of words in the same sentence, like one participant, Gail, who used the phrase '*toxic trio*' to make sense of her triply disadvantaged positionality in the labour market. Note-taking also took the form of conceptual notation, and was interrogative, whereby focus shifted from participant's explicit claim and involved reflection, interrogation, and discussion. On the right hand side of the transcript were the initial comments - descriptive, conceptual and linguistic comments – (see appendix G). This stage of the analysis involved taking the initial notes at face value, through descriptive, conceptual and linguistic notation, and explored different avenues of meaning in details, before developing into interpretative notes.

Step 3: Development of emergent themes

The development of emergent themes (see appendix F) starts at the very top of the transcript, this time analysis takes a volume/data-reduction approach, (see appendix B) as the voluminous data set from the initial note taking stage is the focus of this stage. The transformation of initial notes into themes capture what is really crucial at this point, and reflects the participant's original words and thoughts, and the interpretation of the analyst. In some instances, I merged the second

and the third stage; as I read along, sometimes a theme jumped right out of the data during my initial note taking and as I reflected more on the data, and also drew up my initial list of themes (see appendix G). Once the emergent themes were named, the next stage was clustering them.

Step 4: Clustering themes into a table

This stage involved the establishing of connections across emergent themes (see appendix H), developing a mapping of these emergent themes in the order that they fit, which also means that not all emergent themes get incorporated at this stage (Smith et al., 2009). In analysing my participants' data, I had to discard some emergent themes that were irrelevant to phenomena and answering the research question at the point. The emergent themes that represented similar meanings and understandings, thus identifying a pattern and a connection between these emergent themes were drawn together through abstraction and subsumption. Abstraction meant that themes were pulled together like with like, and developing a new name for the cluster. In some instances, an emergent theme acquired a super-ordinate status by bringing together related themes through the subsumption, like the theme '*coping*' did in my data analysis.

Step 5: Repeating the process for each participant

Following the idiographic nature of IPA studies I wrote up the single case and repeated the process for the next transcript. Each case was treated individually (see appendix I) in commitment to the idiographic element, and that meant bracketing off ideas or emergent themes from previous analysis.

Step 6: Looking for patterns across the cases

Finally patterns across the cases does mean reconfiguring and relabelling of themes, and takes data analysis to a theoretical level (Smith et al., 2009). This was not an easy stage of analysis; I felt a bit overwhelmed at this stage trying to find the connection across the 24 cases. A systematic approach and time spent on the data abstracting and subsuming the emergent themes, resolved this. Furthermore, discussion with my supervisors and valuable feedback was very helpful (see appendix J for master table of superordinate and subordinate themes).

The second phase of interviews were analysed in the same format following the six steps listed above, as the emergent themes related to the coping strategy and involved only eight participants it was easier to merge the emergent themes on resilience with the themes on coping as one continuous process of how the participants coped and how they made sense of their ability to cope as '*resilient Nigerians*'. See the table of themes below.

Superordinate themes	**Subordinate themes**
The process of becoming	Becoming a Nigerian woman in the UK
	Becoming a migrant
	Becoming Black in Britain
	New work identities
Inequalities at work	Disadvantaged in the labour market
	Squeeze before the top
	Work as challenging because of routine racism
Coping with threatened identities	Navigating barriers to good employment
	Seeking out resources for managing the impossible
	Emotional strength

4.7 Positionality

While it is essential for feminist research to 'give voice' to oft-silenced women, it has been argued that it is equally imperative that the choice of methodology and the knowledge production process consider difference and privilege and so minimise inequalities between the researcher and the researched (Gorelick, 1991; McCorkel & Myers, 2003; Stanley, 2013). The research process is usually influenced by the researcher's positionality in any research, and the impact of difference and privilege can influence the data collection and analytical stages (McCorkel & Myers, 2003; Stanley, 2013). Reflecting on one's position as the researcher is an important aspect of an IPA study, hence my reflection on the role that my position, preconceptions, beliefs played in the whole research process.

As the researcher, I occupied an 'insider' position, as I had many common group memberships with all the participants (race, gender, nationality, ethnicity, migrant status), and shared motherhood and marital status with many of the participants. My insider status was useful in the recruitment process, as through snowballing and the sense of 'sisterhood', I obtained chain referrals of potential interviewees from participants, and access to accounts of their experiences. This meant that I had privileged access to the participants, and could pay closer attention to the nuances of the narratives of the participants while minimising mistrust, and so resulted in quality-rich data. An incidence where my insider status helped minimise mistrust, was when a participant invited me to a location (the Imperial War Museum) for the interview. The disturbance from the birds and the howling wind on the grounds of the museum meant we needed a different venue for the interview. The rapport and trust developed in that short time,

based on my insider status convinced the participant to let me into her home and the interview was concluded there and she felt comfortable and free to speak in her own space. The participants identified with me (as a Nigerian, a woman, being Black) as they perceived that I had an empathetic understanding of their racial and gender narratives. They often said "you understand what I mean", or "you understand where I am coming from as a migrant". Having an insider status enabled the understanding of slang and idiomatic expressions that outsiders would struggle to understand. On some occasions, the participants used technical terms on the assumption of shared understanding.

There were areas of difference as well, meaning I also occupied an outsider status, in particular in terms of occupation and professional status. Not being a healthcare professional gave me an outsider status as a researcher which meant I could ask clarifying and curious questions about the nature of healthcare work. But, as an outsider, I was disadvantaged by my lack of knowledge of the socio-politics and socio-cultural factors inherent in the healthcare industry, particular the NHS as an institution. Although this meant I may have failed to ask questions about the organisational culture of the NHS, this lack of knowledge gave me the opportunity to discuss in more depth often taken-for-granted assumptions about it.

Having developed more confidence and established a rapport with the participants during the first phase of face-to face interviews, the second stage of interviews was conducted over Skype to minimise travel expenses, it also allowed a more flexible interview arrangement that met the needs of these busy women. The use of Skype interviews allowed both participants and myself

convenience of time and place in contrast to the initial face-to-face interviews, where finding an appropriate time and space caused delays. I expected secrecy on certain issues from the participants and worried that participants would not disclose their 'sensitive' migration experiences. While none of the participants were illegal immigrants and thus had nothing to hide in relation to their status, they still had personal and sensitive stories to tell. The fact that the participants disclosed their challenging migration experiences is testament to the importance of their experiences, and/or how bad they are or perhaps how little opportunity they have to discuss those experiences. It appeared that talking about those experiences was more important than the culturally-valued practices of not discussing problems; or perhaps it was the case that being in the UK freed participants up to talk to me in a manner that they might not have done in Nigeria. Multidimensional positionalities can thus influence knowledge production and representation in the research process (Merriam, et al, 2001) and in this case, the outcome was that meaningful experiences were shared.

4.8 Addressing Quality Criteria

In qualitative research, the evaluation and assessment of the validity and quality of the research is considered salient as it demonstrates the process of the production of knowledge as well as the fact that the data can be trusted. Assessing the quality of an IPA study requires a detailing of the systematic and conscientious production of knowledge. As an IPA researcher, I made attempts at systematic and objective research, for example by bracketing, writing memos and keeping a reflexive journal about the data collection stage and analysis, and by following the IPA procedure thoroughly. I also kept a paper trail as the analysis process was manually conducted, and followed the recommended steps involved in carrying out an IPA study.

Sensitivity to context was established through recruiting purposive samples of participants, conducting a good IPA interview and ensuring sustained engagement with the particular on a typical idiographic level (Yardley, 2000). As required of a good IPA study, I was careful to commit to a rigorous research process, by reading and re-reading each transcript and engaging deeply with the data to produce rich data through in-depth analysis. A two-phase study facilitated the careful development of interviews to open up participants' freedom to structure the content in phase one as well as to have a more participatory approach, since phase two invited the participants to help in the development of the analysis of phase one. This was a relatively novel feature and thus development of IPA studies.

In striving for high quality, this study engaged with the three elements of a good IPA study. Through making sense of the experiences of the participants, this study addressed the principles of phenomenology, hermeneutics and idiography by studying and interpreting the experiences of these Nigerian women living and working the healthcare section in the UK.

4.9 Conclusion

In this chapter, I have discussed the research method and methodology employed in this study, also providing the rationale for the choice of research method and methodology. The choice of IPA has been presented as the correct phenomenological method to research the experiences of the participants. In addition, the chapter has discussed the key principles of IPA – phenomenology, hermeneutics, and idiography – which facilitated the sense-making of the experiences of the participants.

The following three chapters offer analysis of the data, each focusing on a superordinate theme. Chapter five examines the first superordinate theme, '*process of becoming*'. It delves into and engages with the data to enable an exploration and interpretation of participants' early experiences of migration, starting with how they talked about their process of transition from 'being' to 'becoming', as migration produced the formation of new identities in a new culture and a search for new employment opportunities. Chapter Six follows, it offers an analysis of the superordinate theme 'inequalities at work' examining participants' work experiences once established as a nurse or doctor in the NHS, with a particular focus on how inequality regimes were experienced through interactions between gendered and racialised identities. Chapter Severn is the third analysis chapter, focusing on the superordinate theme of 'coping with threatened identities. It considers participants' coping strategies and interpretations of these strategies within the context of what is experienced as a migrant experience structured by racism and sexism. Throughout the analysis, professional status is used as a lens for exploring potential differences and similarities in the doctor and nurse participants' experiences.

CHAPTER 5 PROCESS OF BECOMING

5.1 Introduction

In this chapter, the first superordinate theme, '*process of becoming*' is analysed. The first section introduces this overarching theme, which focuses on the participants' experiences around the decision to migrate to the UK and what their lives were like as new immigrants in the country. This first section also briefly introduces the four subordinate themes that underpin the superordinate theme, and outlines the structure of the chapter (see table 5.1 below).

Superordinate theme	**Subordinate themes**
The process of becoming	Becoming a Nigerian woman in the UK
	Becoming a migrant
	Becoming Black in Britain
	New work identities

Table 5.1 Table of Superordinate Theme One

5.2 Superordinate Theme One: Process of Becoming

The superordinate theme '*process of becoming*' describes the identity shifts, transformations and representations engendered by the process of migration and its associated demands in understanding and representing oneself differently, particularly in relation to others in society.

The phrase '*process of becoming*' is used to describe how the women transitioned from 'being women in Nigeria', to 'becoming Nigerian women in the UK'. This process involved merging practices from a patriarchal society with those of a more egalitarian society. Being variously identified and positioned as Black, African, and Nigerian migrant women who would eventually gain health service employment in the NHS, the participants' experiences emanated from what they have become. As will be shown below, these women spoke from all these different identities, and from different positionalities at each point in time.

The analysis below shows how the process of becoming in relation to gendered identities was not the only challenge that participants faced. Rather, participants also experienced the process of becoming in relation to a totally new identity – that of being a migrant. Being constructed as an immigrant meant that participants were exposed to biases and negative stereotypes, including of being economic burdens and incompetent in the workplace. Through this exposure, the women began to see and experience themselves as immigrants, and analysis in this chapter presents narrative accounts of how they made sense of being constructed as different and othered as immigrants. These problems of being negatively positioned as an immigrant and as Black were experienced by both doctors and nurses.

Identity changes were a central part of the transitional migration experience, as participants learnt about and engaged in the ways in which identities are produced and reproduced through social differentiation. As such, they experienced a shift in their sense of self, and a consequent loss of a stable sense of self. This loss of self and transition to becoming someone different is

described through the superordinate theme '*process of becoming*'. The title of this superordinate theme thus directs attention to exploring the emerging identities at play in the process of migration. There are four subordinate themes that make up this superordinate theme, which are explored in the sections below. These themes are: (1) Becoming a Nigerian woman in the UK, (2) Becoming a migrant, (3) Becoming Black in Britain, and (4) New work identities.

The analysis of the four subordinate themes is brought together across the doctor and nurse participant groups. This is because their experiences that make up the process of becoming had overarching similarities that were important to draw out. The analysis was therefore able to address research question two by showing how little professional status appeared to impact the experience of migration for the participants. For example, even when on the surface very different circumstances appeared to structure participants' lives – as in the case of the most of the doctor participants, who emigrated as health care professionals while most of the nurse participants did not – the IPA analysis demonstrated that both doctor and nurse participants shared similar experiences, such as a deeply stressful failure to meet their expected immediate career aspirations, a need to retrain, and feelings of being devalued and dis-preferred. However, some differences between the doctor and the nurse participants were found, and these are discussed in the analysis to facilitate further understanding of their experiences.

At the end of the analysis of each of the four subordinate themes, I have chosen to tie my IPA analysis to key conceptual frameworks discussed in the literature review earlier. I do this to facilitate the IPA analysis, using these frameworks to enhance my understanding of participants'

sense making. The wider literature and analytical concepts of becoming and intersectionality discussed in chapter three are also brought into the analysis in the final section of this chapter, which discusses the findings in relation to the research questions. The chapter finishes by offering a final conclusion to the analysis of the process of becoming. This structure of analysing the subordinate themes with a focus on the participants' sense making, followed by an analysis tying their sense making into relevant conceptual frameworks to enhance the analysis, is repeated in the subsequent analysis chapters.

5.2.1 Subordinate Theme One: Becoming a Nigerian Woman in the UK

Participants described their move to the UK as an experience of migrating from a patriarchal society to a society characterised by gender-neutrality. Participants either explicitly described Nigeria as a patriarchal society and/or told stories of how it was expected that the men in their family – such as their fathers and husbands – would make decisions for them, including the decision for them to migrate to the UK. Characterising the UK as a society structured by gender equality, participants experienced their move to the UK as producing a shift in their experience of gender relations, which effected their practices of womanhood and created particular challenges. These challenges were experienced at the intersections of raced, gendered and national or geographical positionalities, so that the experience of migration was one in which participants had to adjust to new ways of not just becoming a woman in the UK, but becoming a Nigerian woman in the UK. Below, I describe these transitional challenges by exploring participants' individual experiences of the migration decision-making processes, while also showing the commonalities in these experiences. In particular, I show how, as Nigerian women,

participants often had no or little voice in the decision to migrate and how their experiences continued to be gendered in the UK, despite their understanding of the UK as a gender-neutral society.

Participants described a range of pathways for their migration. Categorising these into dependent or primary migrant pathways shows that approximately half the sample were dependent migrants, with nine participants entering the UK to join their husbands and one gaining entry as a child, under a family visa. Of the other 14 participants, two were married and went to the UK ahead of their husbands, as primary migrants, while the others came into the UK as students (including undergraduate and postgraduate non-medical and medical training programmes). Nearly half the sample (10 women) also indicated that they had little or no agency in the decision to migrate; this lack of agency cut across the categories of dependent and primary migrants. Below is an example of how participants described having no choice to migrate, and how this lack of choice was deeply gendered.

> *"It wasn't as if I needed to make a decision; it was more or less because, you're married now and as everyone would expect, you should be living with your husband. So it wasn't like I had an outright choice to make. It was just "you had to go"* (Gail, nurse)

Gail's decision-making process to emigrate was profoundly structured by her position as a married woman. She '*had to go'* not because she was a woman but because she was a married woman, which tied her to the cultural expectation of her Nigerian society that the husband's place of residence determines the wife's. In Gail's case, this required her to migrate from Nigeria to the UK. The above extract highlights Gail's understanding of the socio-cultural expectation of a married woman in the Nigerian setting, which is seen in the readiness in which she accepted

her fate. Gail's understanding of this cultural/social expectation is quite totalising – '***everyone*** *would expect you'd be living with your husband*' – and this expectation cannot be resisted since she '*had to go*'.

There is a sense of Gail accepting her fate. She had no '*outright choice*' in this extract, since she does not question or criticise this societal expectation, nor does she say what her own desires were. Rose, a doctor-participant, describes a similar experience of joining a husband without volition. However, unlike Gail, Rose does express a preference – she would have preferred not to have gone.

> *"I came to join my husband here. He was already living here. We got married and I came to join him. Before I came to the UK, I was practising as a doctor in (name of city), Nigeria … Decision to come here? Is it not (husband's name) that I followed? (laughs out heartily) ... So it is not as if, I decided, I packed my bag and, you know, and came to the UK … Maybe if I had a choice, I probably wouldn't, it is not still my choice now"*
> (Rose, doctor)

Rose's extract starts with a similar tone to Gail, whereby being a married woman means joining her husband ('*We got married and I came to join him'*). However, she also reflects on her position as a doctor, perhaps with its implications of independence and high status, before returning to the question ('*Decision to come here?'*). This time, her answer – a rhetorical question ('*Is it not (husband's name) that I followed?')* followed by laughter – holds a critique of her lack of decision making power, and of the ability to have autonomy or exercise volition ('*So it is not as if, I decided'*). The laughter and rhetorical question convey information about her emotional state over the decision for her to migrate. In this, Rose appears to use her laughter and

rhetorical question to both express rhetorical affirmation of her role as a subservient wife, who '*follows*' her husband, while simultaneously troubling this affirmation.

In contrast to Gail, Rose is less accepting of her fate, even though she still does what is asked of her and follows her husband. The lack of agency around this decision is experienced in a painful way, and remains salient since it is part of both her past and her present, as it is still not her choice '*now'*. Rose would not have migrated if she had had a choice and evokes a sense of loss in relation to leaving her job as a practicing doctor in Nigeria. The process of becoming for Rose thus includes an ongoing sense of loss – of a former self and of current agency.

An understanding of the experience of the decision to immigrate is further developed from Olivia's interview below. Olivia, like Rose, also had no choice in the decision to migrate, and like Rose, left her job as a practising doctor in Nigeria. However, more like Gail than Rose, Olivia's experience is characterised by acceptance, showing that there were also similarities across the doctor and nurses' interpretations of their lack of choice.

> *"I came to the UK, specifically five years ago, after I got married. I met my husband back home in Nigeria, he was based here in the UK working already, and I had no choice but to move over … I was working as a doctor in Nigeria before I moved to the UK, I had to leave work (…) after I knew I would move to the UK after we got married, I was a bit apprehensive about the idea, because I felt it was like going to be a total culture shock, I was expecting a real culture shock. Like I am coming from Nigeria where I have been working as a doctor and I have lived all my life, now getting uprooted"* (Olivia, doctor)

Olivia demonstrates acceptance of the expectation to follow her husband, saying '*I knew I would move to the UK after we got married*'. However, while she accepts the expectation that she will follow her husband and that there would be '*no choice but to move'*, the decision is not easy for her. Her thoughts about moving to the UK are apprehensive, and she focuses on concerns about living somewhere very different which would require plentiful psychological resources to deal with the expected '*total culture shock'* and feeling of being '*uprooted'*. Thus, migration represents a similar loss for both Olivia and Rose, with both focusing on losing their jobs as a doctor.

Olivia's feeling of being '*uprooted*' also signifies a move from the known, which offers security and certainty, to the unknown, a displacement from a secure position, as well as a loss of connection from the life she has always known and her secure professional identity as a doctor, meaning she is less willing to relocate. Immigration signified both a loss but also a move towards something fearful – a culture shock rather than the 'better life' of more well-known narratives of immigrant expectations, as can be seen in the literature review of the migrants attracted to the UK for career development opportunities (Healy & Oikehome, 2007).

Olivia's account corroborates Rose and Gail's in terms of having no agency in the decision to migrate due to a change in marital status. All the women offer examples of experiences from participants who as ***dependants*** migrated with no agency in the decision-making process. However, even participants who were the ***primary migrants***, as in Jennifer's example below, described not having agency in the decision to migrate.

> "*It was my husband that made the decision for me … I think he felt I had much more to offer. I think he probably felt, after the youth service*[1] *I was just doing locums, so he felt I'd have better opportunities here. So he sent me here and followed suit afterwards*" (Jennifer, doctor)

Despite her role as the primary migrant in her family, Jennifer's narrative is similar to those of the participants above, in the sense that the life-changing decision to migrate was made for her. Just as the participants above evoked patriarchal understandings that associated marriage with being subservient to the husband – following them without choice – so Jennifer has decisions made for her by her husband. In this case, Jennifer's husband assessed her situation, decided she'd have better working opportunities in the UK and '*sent her*'. Despite Jennifer's status as a highly successful professional woman, there is no indication that the decision to migrate on the basis of her skills might have occurred as a result of shared discussions and decision making with her husband as her life partner. However, there is a level of understanding from Jennifer about her husband's decision to send her to the UK, as she uses the word 'felt' several times, discussing his feelings about her potential (*'I had much more to offer'*), and about the UK offering her '*better opportunities*' than Nigeria did at the time. There is a sense of her understanding his decision for her to migrate, while also indicating she had no agency in the decision to migrate.

Decisions about life-changing situations being in the remit of the husband were described in ways that showed the experience to be normal and naturalised for most of the participants, who talked about the decision to migrate not being theirs in a matter-of-fact manner. However, the

[1] [compulsory one year of work - country development service - by Nigerian university graduates]

fact that participants accepted this lack of agency did not mean that they found the experience easy; the emotional tone of their talk was often one of sadness and loss. A few participants, like Rose, were unusual in explicitly saying they would not have migrated if they had a choice, while another unusual participant, Vicky, indicated that the decision to migrate was made with her husband in partnership. However, these two women were exceptions. Most participants described a norm in which Nigerian husbands made important decisions about their wives, and their wives accepted this. This norm structured many of the participants' experiences, so that migration was not experienced as a personal choice, but as an external decision which must be accepted.

A key pattern thus emerged in which participants described their sense of self and agency as profoundly gendered, where women functioned in supportive roles, and the men (fathers and husbands) made decisions about, and for them. This extract from Flora confirms the acceptance of this supportive role of women in Nigeria as a norm.

> "*A woman's role is more of a supportive role in the family, even if you earn more, or your career is way ahead of your partner's, your role should still be supportive. I did not feel there was any need to give up such values you know, it, sort of, anchors you and keeps you grounded*". (Flora, nurse)

Vicky (nurse) explained the belief systems which underpinning gendered decision making: '*African culture can be very patriarchal, that women should be below them*'. Participants had thus grown up within the context of a patriarchal society in which they had learned to practice womanhood and from which they migrated. This gendered sense of self and the associated

gendered norms were significantly undermined as participants migrated to the UK, which they experienced as a profoundly different society, structured around gender-equality.

The process of migration thus required participants to adjust the manner in which they practised womanhood in the UK, a process of becoming that this thesis conceptualises as a process from being women as understood in Nigeria to becoming Nigerian women in the UK. This is because participants did not experience a shift from patriarchy to equality or from being Nigerian to British women. Rather, their lives in the UK were lived out through complex intersections between multiple gendered norms associated with being both Nigerian and living in the UK. Thus, the move to the UK was not one of swapping patriarchy for freedom, but swapping one set of gendered issues for another.

For example, in Nigeria the men in the participants' lives might have made certain significant decisions for them, but they had a range of ways of expressing agency and autonomy, such as being able to train for and access professional jobs or the choice to stay at home and focus on domestic tasks, and often in either situation, participants were able to buy in domestic help. This level of choice was not available in the UK, since salaries and living costs meant that the women had to earn money to contribute to the family's finances and could not afford to pay for significant domestic labour or support.

As explored in the extracts below, participants' experience of moving to the UK required them to negotiate a complex, multiple set of identities. They were required to work like a British woman,

or like a Nigerian man, as some indicated that it was the man's gendered responsibility to work and provide for the family, yet take care of the domestics like a Nigerian woman, hence becoming a Nigerian woman in the UK. Theirs was an intersectional experience across axis of economics, gendered, nationality and cultural identities that was not in any way a pleasant experience since it required huge psychological shifts and was characterised by relentless hard work. As Beverley (doctor) described, it "*was a lot to adjust to*". The extracts below demonstrate how these women experienced and adjusted their gendered identity in the UK.

> "*Being a woman in the UK is not like a being a woman back home. Back home in Africa you can stay at home and look after the kids while your husband goes to work and brings the money, but in the UK, everybody works and the money has to come in from everywhere and you have to help out*" (Helen, nurse)

Helen's narrative provides a comparative perspective on the differences between the two societies. She highlights the variations in gender roles between the single-earner, male breadwinner family model back home, and the dual-earner family model in the UK, in which the woman also bears a portion of the family's financial responsibility. Domestic and financial responsibilities are gendered and separate in Nigeria, but Helen experiences a different type of gender relations and family dynamics in the UK. There is a sense that this added financial responsibility being overwhelming for her, seen from her emphasis on *'every*', in the sense that '*everybody has to work*' and the need for finances from '*everywhere*'. Although she is included in the '*everybody works'*, she still talks about how she has to help. Here, Helen describes the domestic role in Africa in choiceful terms, saying '*you can stay*' rather than you have to stay, while her UK experience is less volitional since '*everybody works'.* The language of this latter statement gives a sense that she does not experience people as having choice in the UK.

For many of the participants then, migration involved a lack of agency – in the decision to immigrate and equally in what they could choose to do when they came to the UK. Above, Helen made sense of living a different and challenging life since becoming a Nigerian woman living in the UK. Below, Sharon's narrative about being a woman in Nigeria/Africa supports Helen's, further developing this analysis with another example of a greater perception of choice in Nigeria.

> "*Back home you can be a housewife and your husband goes to make the money then you can do things at home and keep the house nice and tidy, but here you have to do everything, even though you come back at 11pm you are still expected to get into the kitchen and do things, that's our culture, our Nigerian mentality… for a Nigerian woman, the woman always has the kitchen work and the house work to deal with*" (Sharon, nurse)

Sharon explains how becoming a Nigerian woman in the UK meant she had to merge the cultural 'imports' of womanhood, combining her different understandings of what is required of womanhood in the UK and Nigeria, joining financial with domestic responsibilities. She highlights that when she says '*but here you have to do everything'*. Sharon perceives that doing '*everything*' is a product of becoming a Nigerian woman in the UK. The environment and the nature of the society is irrelevant for the '*Nigerian woman*', in that wherever she is, she is always responsible for the domestic work. However, moving to the UK means the elimination of the housewife role, a role described here with positive associations since you can keep the house '*nice*' and '*tidy*', and you '*can'* do things at home.

In contrast, the move to the UK produces overwhelming dual requirements of UK paid employment (until 11pm, pointing to the hard work of shift work of nurses) and what Sharon

sees as Nigerian full domestic responsibilities, '*get into the kitchen*'. Doing both paid employment and having domestic responsibilities is what Hochschild (1989) called the 'second shift', which she understood to be a burden shared by many women in Western societies where the norm, enshrined by equality legislation, is for women to be in paid employment. However, Sharon understands this as produced from being both UK-based and culturally Nigerian, the outcome of which is the worst of both worlds – a trying challenge that can only be met by significant and relentless hard work.

Helen and Sharon emphasised the possibility of being a housewife as part of womanhood in Nigeria. In the context of doing the 'second shift' in the UK, the role of the Nigerian housewife takes on an attractive element, as it is something women can do in a way they cannot in the UK. Part of this retrospectively positive interpretation of the Nigerian housewife role is related to the ability to do it well. As an example, Sharon's comment "*keep the house nice and tidy*", implying an ability to do domestic work without exhaustion is not possible when coming home at 11pm from working as a nurse (see Sharon's extract above), or when domestic help is not easily bought, as Irene explains below:

> "*Being a woman, having children, you find that, you just have to do that bit extra (…) It's been more difficult here, in the sense that hmm, coming here, you don't have any help … You have to drive yourself, wash your own clothes, look after your own home, do all your chores yourself, compared to, in Nigeria where I didn't have to do those things, you have help. You have people who will do it for you at affordable rates*" (Irene, nurse)

Irene's narrative centres on the availability of outsourcing of her gendered domestic work in Nigeria in ways she cannot afford in the UK. There is a deep sense that doing the domestic work

is important, partially as it assists in understanding oneself as a good woman. Moving to the UK makes '*being a good woman*', in Irene's own words, '*more difficult*' to do because of reduced resources – be that time (as these women are working) and/or money (to buy labour/outsource that gendered responsibility). The experience of becoming a Nigerian woman in the UK as harder work is seen in the extracts from the nurses, above. However, the doctors also described this experience, attributing their second shift to identity and gendered norms as Anne, a doctor, explains below.

> "*Then again I am a wife, when I come back from work and I am married to a Nigerian man that expects me to make sure that as I am coming back food is there … Even if we step through the door at the same time, I have to start sorting out the kids, cooking and make sure there is something in the house, I think it is a cultural thing as well. So that makes it a little bit hard for me, because you know other cultures, sometimes their husbands are stay-at-home dads, taking care of the kids, do you understand, [int.: house-husbands as they call it]? They will cook food, there will be food in the house before you come back home*" (Anne, doctor)

Despite being a doctor and likely to have more financial resources than the nurse participants, Anne also describes the nature of the experience of becoming a Nigerian woman in the UK as one of hard work. Anne's second shift is understood as being particularly produced through Nigerian identity ('*I am married to a Nigerian man*'). Again, there is a feeling of not being able to escape the double-demand expectations to both engage in paid work like a man '*even if we step through the door at the same time*' and work at home like a Nigerian woman, '*I have to start sorting out the kids, cooking and make sure there is something in the house*'.

At the start of the extract, Anne interprets the second shift as an identity of being a wife, but moves this to also include her interpretation of her experience as being a '*cultural thing'*. Her

interpretation of this experience is thus linked back to expectation that being married to a Nigerian man means behaving like a woman the Nigerian way, even when residing in a country where egalitarian gender relations are valued and practised (‘*their husbands are stay-at-home dads … house-husbands’*), and where culturally and/or economically, Nigerian women are required to go out to work like men. Anne’s account, like many of the participants, thus indicates that her lives is structured around gendered expectations, since she is married to a Nigerian man who ‘*expects me to…*’.

Rather than challenging traditional female roles, Anne, like most of the participants, accepts the expectation. However, there is also a sense of ambivalence towards adhering to these expected behaviours and values, as she looks wistfully at ‘*other cultures*’ in which men take on the domestic roles. In so doing, Anne expresses an unmet need in her life for her husband to help with household chores and childcare (‘*that makes it a little bit hard for me’)*. Again like other participants, Anne highlights a sense of self as de-centred, living a different life in the UK.

The above analysis of Gail, Anne, Rose and Olivia’s experiences demonstrates the ways in which these participants had to negotiate external cultural expectations that made emigrating particularly hard for them, resulting in an intensely experienced second shift. However, these participants also described how these cultural expectations were internalised so that in doing the domestic work, they can be understood as ‘doing gender’. Domestic work was thus an important mechanism for allowing the participants feel like good Nigerian women, as Karen explains in the extract below, with her description of a good woman. The extract starts with a discussion of the

advantages of earning a good salary working as a doctor in the UK and having a husband who, highly unusually, has adjusted his gendered expectations and now also contributes to the domestic work of the family.

> "*The positive impact being that you can afford whatever your kids want, it makes you comfortable. Looking at the negative side, you know, as a woman, you don't have enough time for your children, you don't have enough time to be a good wife to your husband. Knowing the society that I come from, where the woman is supposed to be in the kitchen, look after her husband and kids, do all the house chores, being in this job does not allow you to be that way … So the things a woman should do, which I have not been able to do, he's having to do them*" (Karen, doctor)

Karen's experience, in which her husband changes his behaviour on migrating to the UK, is unusual, and allows her to share the burden of adjusting to a new setting that requires different gendered roles. However, Karen's narrative is hardly celebratory; instead, she focuses on her feelings of guilt over not being able to be a '*good wife'*, or be '*where the woman is supposed to be'* – the kitchen – as well as her inability to do the things that *'a woman should do'*.

Karen describes a lack of choice and agency in selecting her desired kind of womanhood. Her workload as a doctor means she does not '*have enough time*' to do the things she associates with being a woman, namely, caring for her children and husband. The power of this traditional female role in relation to her identity is evident in that not being able to perform it is experienced as deeply problematic. In not being able to do '*the things a woman should do*', she loses her ability to understand herself as a (good Nigerian) woman. Karen sees herself deviating from the cultural constructions of womanhood and *becoming* a different kind of woman; however, there is a sense of her ambivalence towards this emerging woman. While there is value in being a doctor

and being financially secure (‘*you can afford whatever your kids want’*), the consequence is the surrendering of important culturally-valued aspects of her identity as she ‘*become[s]’* this Nigerian woman in the UK.

5.2.1.1 Summary of Subordinate Theme One: Becoming a Nigerian Woman in the UK

When theorising the process of becoming as part of globalization and migration, Hall suggested that identities undergo constant transformation and change in the process of migration. Migrant identities are thus neither unitary nor fixed in some essentialised past, but are fragmented and constantly transformed (Hall, 1990). The analysis above demonstrates how the *‘process of becoming’* for the participants in this study involved a shift from a once-fixed and culturally-produced identity as a woman in Nigeria (with its associated practices of womanhood) to an experience of competing, multiple and potentially fragmented identities as previous notions of womanhood learnt in Nigeria rubbed up against the culture of the British dual-earning family structure and what it means to be a Nigerian woman in the UK.

Many of the participants were located within relationships that were structured around patriarchal gendered roles, where women held less status than men (for example, in being expected to follow their husbands to the UK), and where they were expected to prioritise their domestic, childbearing and child-rearing responsibilities (Imamura, 1990; Reynolds, 2006). After emigrating to the UK, traditional gender roles that were part of their Nigerian culture continued to structure many of the participants’ experiences in their UK domestic sphere. This is an

experience that can be summed up as the process of becoming Nigerian women in the UK. Participants' experience in relation to becoming a Nigerian woman in the UK thus aligns with Hall's theory about migrant identity processes, but in particular, highlights the importance of gendered identities as transformed through immigration into the UK.

Thus, a key part of the experience of being a migrant was the process of becoming as the participants adjusted to their new environment, and encountered important losses (of a role that defined them, and of jobs), as well as the associating discomforts and ambivalences of becoming someone in this new social and cultural space. This process of becoming was structured by having grown up in a patriarchal society where men make decisions for women, and women are responsible for the domestic sphere, and measured their worth in terms of how well they take care of their husband, children and home, even while they participated in paid, professional employment. These norms were thrown in sharp contrast following the process of migration to the UK, where the expectation and economic requirement was for the women to engage in significant levels of paid employment without relinquishing their domestic responsibilities or (for the majority) having husbands willing to take on some of these roles. The outcome was a second shift, conceptualised as an experience produced not by modernity as theorised by Hochschild (1989), but through the intersections of gendered and national cultural norms, in this case, the intersections of being Nigerian women, with a gendered identity located in Nigerian sense-making, but based within the context of UK economics and expectations of gender neutrality.

Both the pre and post-migration experience was characterised by a lack of choice and limited agency for the participants, who neither chose to migrate nor were able to free themselves of excessive labour once in the UK. Participants attributed this lack of choice to the economic conditions of the UK as well as to (Nigerian) societal expectations and their internalisation of these expectations. Both of these conditions were interpreted as being outside of participants' control, so that a pattern emerged in which the women described accepting their fate, even if they felt ambivalent about it. This acceptance was in part related to identity, since an understanding of themselves as 'good women' required participants to 'do gender' by performing the traditional female role regardless of where they lived. The process of becoming in relation to gender was thus complex and ambivalent; characterised by a sense of loss (of past selves, valued identities, freedom or choice); and only (partially) resolved by excessive hard work that required a huge draw on participants' personal resources.

The process of becoming in relation to gendered identities was not participants' only challenge. In the section below, I explore how participants also experienced the process of becoming in relation to a totally new identity – that of being a migrant.

5.2.2 Subordinate Theme Two: Becoming a Migrant

The participants crossed not only a geographical border, but also social and political borders, emerging in the UK as immigrants. Being constructed as immigrants meant they were exposed to biases and negative stereotypes, including being economic burdens and incompetent in the

workplace. The narratives below show how these women began to see and experience themselves as immigrants, as well as how they made sense of being constructed as different and othered as immigrants. Below, Beverley highlights her experience of other's perception of immigrants as being incompetent.

> "*they [British colleagues] tend to generalise, all these Africans, migrants, so they wouldn't take it on an individual basis … they will just take it that all these migrants they don't know what they are doing. So in that way I think it affects how people perceive you*" (Beverley, doctor)

Beverley reflects on being perceived through negative stereotypes, where she is not dealt with on an individual basis but is instead understood to be part of a generalised collective of African immigrants who '*don't know what they are doing*'. Beverley indicates her awareness of being perceived as different, with terms like '*they*' and '*us*', using 'they' to refer to both immigrants and indigenous people. She describes a new sense of identity, grown through the process of migration and becoming an immigrant since she understands how her African/migrant positioning structures how others interpret her ('*it affects how they perceive you*'). This identity is unwanted, unhelpful and unmeritocratic since '*they wouldn't take it on an individual basis*'. The way Beverley distances herself from this experience while also being the subject of it (for example saying 'you' when she could have said 'me'), suggests it is painful to talk about.

Negotiating negative perceptions of migrants was a reoccurring pattern in participants' early experiences of moving to the UK. Eileen, a nurse, narrated a similar experience to Beverley, saying '*sometimes you hear them complain about all these immigrants'*. Another example was

highlighted by Flora (nurse), who described how being an immigrant meant that part of everyday life in the UK involved her needing to demonstrate the validity of her status.

> "*Yes, as a migrant I feel limited, I feel I have to prove myself, you know. Even when you go somewhere, you do know it is only when you are a migrant that they have to phone the Home Office to ascertain that your indefinite leave*[2] *is a true indefinite leave, even though you have given it to them*" (Flora, nurse)

Flora's experience of being an immigrant is one of limitation. She describes feeling as though her credibility and integrity are constantly questioned and under scrutiny ('*I feel I have to prove myself'*), which is a by-product of her immigrant status. The repetition of the word '*even'* emphasises the surprise and frustration she feels at unexpected checks, being doubted, and the length the officials go to ('*phone the Home Office'*) even though they have the physical evidence in their hands that she has '*a true indefinite leave'*. The perception that immigrants are undervalued and have to deal with extra difficulties at work was also a theme in Helen's talk, below.

> "*As a migrant, as an African, you don't have the British accent there are a few things you go through when you are at work (…) sometimes your colleagues pretend or they feel they don't understand what you are saying, sometimes they think you are not good enough because they know you are not from here, and whatever opinion you give is not valued*" (Helen, nurse)

Helen's emphasis on her accent and ethnicity highlights aspects of her identity that accentuate her experience of being an immigrant. This in turn produces particular experiences at work, such as not being understood, valued or listened to. She interprets her colleagues' behaviour towards

[2][permanent immigration status]

her – the pretence – as a deliberate act to make her feel 'othered'. Helen perceives the way she is treated as a threat to her identity, and she feels positioned as someone unable to do a good job ('*they think you are not good enough'*) and whose opinion is not valued. This is as a result of being different ('*you are not from here*'). Being an immigrant is thus the experience of being subjected to social prejudice by colleagues. Migration is thus perceived as a process of becoming othered.

The problems of being negatively positioned as an immigrant were experienced by both doctors and nurses. Mary, a doctor, voices her experience of feeling 'othered' and different because she is a migrant.

> "*First of all being a migrant, I think one of the things that stood out for me as a migrant, as soon as people saw you they want to know where you are from, where you are originally from, hmm, even if you are British and you say you are British, people want to know where your parents are from. You know, it doesn't ... doesn't just stop at you, people want to put you in a kind of box, to label you, and straight off there is a sense of we are different, a sense of division that is already created in such queries*" (Mary, doctor)

Mary describes being 'othered' as a migrant as a significant experience of moving to the UK ('*one of the things that stood out for me'*), whereby others treated her migrant status, rather than her as an individual, as central to how they understood her (*'It doesn't just stop at you').* Being visibly different (*'as soon as people saw you'*) positions Mary as a migrant, producing a set of questions as to where she is from that is experienced as 'othering' her, since any claim to British status are rejected (*'where you are originally from … where your parents are from'*). This line of questioning upsets Mary since it 'others' her by creating '*a sense of division*'. She

metaphorically describes it as being put '*in a kind of box'* and being labelled as '*different'*. Such questioning, which makes Mary feel excluded, appears to be a frequent occurrence for her, standing out as a key experience of moving to the UK and evident in the statement '*as soon as people saw you*'. This question was a constant reminder of her immigrant status and Mary felt as though her British citizenship status, acquired by naturalisation, was rejected and invalidated on the basis of her immigrant status.

Rose describes being asked similar questions to Mary, emphasising the relentlessness of these questions, how they are attributable to being positioned as an identifiable, visible migrant, while also being tied into another negative perception associated with an immigrant status – that of economic opportunity grabbers.

> "*You are always seen as a migrant. Everybody asks you where you are from originally. That 'originally' must come in. Also my accent – I don't have a British accent so it's obvious that I'm foreign. Even if – my colour, people may say maybe I was born here but my accent also gives me away. Sometimes people used to pick on the fact that you are a migrant. People want to ask why did you come here – why did you come here - almost everybody. You know, sometimes they feel you've come to grab the opportunities that British people will have*" (Rose, doctor)

Rose describes the oppressive nature of questions that work as constant reminders that others see her as a migrant. She highlights this when says '*always seen as a migrant'*, or describes how people always '*pick on'* her immigrant status and where she is originally from. There is a sense of being unable to escape from being positioned as migrant since her accent, if not her colour, would give it away. Rose feels obliged to be an immigrant against her desire as she indicates that *'you are always seen as a migrant'* in this new social environment, with all the associated

negative stereotypes. Rose perceives that there is no hiding her immigrant status in a context that makes her vulnerable to prejudices and questions about her origin and which she experiences as hostile and overwhelming. It is not just where she is from that she is asked but also why she came to the UK, a question that '*almost everybody'* asks in relation to negative stereotypes of migrants as exploiting British opportunities.

5.2.2.1 Summary of Subordinate Theme Two: Becoming a Migrant

The process of becoming in relation to becoming an immigrant involved negotiating a completely new – and negative – identity which was produced by migration. This experience reiterates the view that immigrants have been constructed and categorised into the desired and undesired (Sales, 2002; Charteris-Black, 2006; Anderson, 2013). However, negative representations of immigrants dominate in public discourse, particularly the UK media, thus constructing the identity of immigrants as problematic, unwanted, undeserving and unworthy outsiders, who would potentially deplete the resources and wages of the indigenous people (Sales, 2002; Salter, 2003; Sollund, 2012; Blinder & Jeannet, 2014).

In Hall's view (1991), identity is never complete or finished, rather it is always in process, as new identities emerge from the politics of position. Further, the process of change and the transformation characteristics of migration disturb the relatively 'settled' and fixed identity of those who migrate; a process, as discussed above, that Hall conceptualises as a shift of identity from 'being' to 'becoming'.

Immigrant identities described in the participants' talk were reviewed on the basis of Hall's theory of identity and representation (1997c), which emphasised the construction and positioning of identity through language, representation, and meanings. In the UK, the identities of immigrants are constructed as dis-preferred, categorised and 'othered' in various ways, for example, as 'unwanted outsiders' (Charteris-Black, 2006). The experiences of these women illustrate this construction of an immigrant identity as unwanted and generally as problematic. Hall (1996a) argues that the process of becoming is situated within the representational practices of migrants' new cultural location, which produce new realities as well as differentiated and complex migrant statuses. As the analysis above showed, for these participants, the *process of becoming* involved seeing themselves through the eyes of, and in relation to, indigenous others as migrants rather than individuals, a process so normalised in British people that Rose, for example, described it as part of everyday life, in which she received 'othering' questions from '*almost everybody'* she met.

The extracts in section 5.2.1 demonstrated participants' new realities as well as the ways in which linguistic and visual difference brought both doctors and nurses undue attention and a constant questioning of their legitimacy. As visible, identifiable migrants, participants lost the ability to be understood as individuals. Instead, their experiences resonate with Hall's work on how new identities become situated within representational practices of their new cultural location. The analysis above shows how the wider public negative rhetoric of economic migrants is being directed towards, and experienced in, the everyday lives of the doctors and nurses. By understanding the experiences of the participants in a wider context, these findings illuminate the extant literature reviewed in chapter three, and highlight the current hostile climate for migrants

in the UK. However, becoming a 'migrant' was not the only new identity that participants' had to negotiate. As they found out, they also had to adjust to a racial identity, becoming Black in Britain, which will be discussed in the section below.

5.2.3 Subordinate Theme Three: Becoming Black in Britain

By migrating to the UK, participants became aware of, and acquired a new racial identity, of becoming 'Black'. In Nigeria, participants had never been identified as 'Black' or experienced being a visible minority, and all the associated subordinate status that comes along with this. Thus migration produced a process of becoming new subjects in the politics of identity and position. The reality of '*becoming*' Black, in addition to '*becoming*' an immigrant, was part of the experience of migration. This was a significantly challenging experience for many of these participants, as they came to understand the meaning and representation of 'Blackness' in the UK. The racialised experiences of the participants embedded within institutional and organisational practices and processes are explored below.

> *"The other challenge is obviously I'm Black, coloured, you walk into a ward you are the only Black person, you tend to notice such things. Things that you were not worried about back home started to surface"* (Rose, doctor)

Rose gives the impression she is confused about how to identify herself, as '*Black, or coloured*'. This is a challenge associated with the process of migration for Rose. She describes being visibly different at work because she was the only Black person. The act of walking into a ward as a doctor seems easy, but walking into a ward with the awareness of being the only visible minority had a psychological impact on Rose, leaving her in a state of anxiety and worry. The sudden

anxiety associated with her racial identity is nothing to do with her skin colour, which obviously had not changed since her migration to the UK, but rather she referred to the meaning and representation of this 'Blackness' when she said '*things that you were not worried about back home started to surface*'. Her choice of the word '*surface*' indicates that skin colour was present but not 'visible' in relation to others in Nigeria, and thus had no associated meaning or representation, and definitely nothing to worry about until she migrated. Even Rose's professional identity as a doctor did not mediate this racialised experience since in that public space, it was challenging becoming Black, being obliged and compelled to take on a new 'worrying' identity in her new environment.

Similarly, Jennifer describes being the only Black person in her work, and how Blackness is used as a category in Britain in ways that ignore significant differences between the people who are labelled 'Black'.

> "W*here I work, I am the only Black person in the whole surgery, so amongst the doctors, nurses, admin staff, I am the only Black person here…I sense that there is something different about me…It is quite interesting that the Caucasians lump us as Caucasian and others, because the others they are calling us the Black African is actually different from the Black Caribbean, extremely different*" (Jennifer, doctor)

Jennifer indicates a conscious awareness of being the '*only Black person'* at her place of work. She reviews across the different staff at work – doctors, nurses, admin staff – and concludes that she is the '*only Black person here'*. This gives her a sense of being '*different'* in relation to the others. She feels 'othered' and, when making sense of this new identity, self-identifies as Black

African. However, she is '*lumped*' in with other different ethnic groups as a representation of Blackness in the UK. Migrating to the UK and working in a white dominated environment, Jennifer experiences a process of becoming someone who is, like Rose, visibly different, and is defined by the racialised identity 'Black', which is the product of social interaction with Caucasian people, who see her in terms that are not how she sees herself. She feels that her ethnic identity (African) is disregarded in the racial categorisation of African and Caribbean people as Blacks. In addition, she has to adjust to such emerging 'otherness' and sameness in becoming Black in the UK, while also adjusting to how racial difference is represented and 'othered' through the perception of Blackness in Britain. Flora also experiences otherness in the extract below.

> "*You see, you have all these Black nurses treating all these white, British, Caucasians, it was, they were always, the way they view you is horrible, isn't it? Then they come up with these questions like, "where are you from originally", and then I am like, "why do you assume I am from somewhere else, what do you mean by originally?" oh you say something like I am British, but they ask, but where are you from originally?*" (Flora, nurse)

Flora asked this rhetorical question, highlighting the way she feels she is perceived as a Black person and indicating the divide between the racial identity of the participant and that of the nurses and the white patients. She then describes in great detail the experience of being interrogated about her identity, finding particularly disturbing the question '*where are you from originally?'*. Flora describes how such questions demonstrate that the speakers disbelieve and doubt her authenticity as British, so that they create a racial category of 'Blackness' that is incompatible with Britishness. Earlier on, authentic Britishness was questioned and doubted when discussing being an immigrant. Here, Flora has a similar experience of her Britishness being viewed as incompatible with Blackness. Indeed, Blackness and migrant status were often

conflated in participants' experiences of how other people treated them at work, as in Anne's example below.

> "*I found out that everybody has a stereotype in their mind as to how they think of someone who is a Black doctor, where are they coming from, you know, what country are they coming from, do they really know what they are doing*" (Anne, doctor)

By referring to *'everybody'*, Anne describes an experience in which it feels as though all the people she meets at work perceive her through a negative stereotype of a '*Black doctor'*. These negative stereotypes legitimate a set of questions about these doctors' country of origin and their capabilities ('*do they really know what they are doing*?'). Anne found that coming to the UK produced a new sense of racial identification, racialising her sense of self and professional status. She was now a 'Black doctor', which creates a need to negotiate associated and problematic negative stereotypes about her legitimacy as a healthcare professional in the NHS. Other examples included Davina, a doctor, who noted that her colleagues at work "*don't expect much from you because you are Black*"; and Nina, a nurse who explained that Blacks "*do not belong"* at work because they embody an inferior race and identity.

Becoming Black meant adjusting to new identities as well as to nuanced meanings and representation of Blackness. This will be considered further in the section below.

5.2.3.1 Summary of Subordinate Theme Three: Becoming Black in Britain

The analysis above describes how participants' migration to the UK was experienced as a process of becoming tied into learning to understand themselves through a new identity of being

Black, an identity imbued with negative connotations experienced by both nurses and doctors, so that professional status did not protect doctors from or mediate the experience.

Participants' experiences of learning to understand themselves as 'Black' mirrors Hall's (1997a) description of migration to the UK as a Black man in the 1970s, highlighting parallels between the experiences of Black people migrating to the UK now and in the 1970s, bearing in mind that 1970s British culture was often associated with racism (Gilroy, 1987). As discussed in chapter three, it was in Britain that Hall (1997a) experienced a redefinition of identity and being identified as Black. Hall (1997a) conceptualised the identity category 'Black' as a signifier and pointed out that the process of Black identification signified the consciousness and learning of one's identity from the position of the 'other'. The process of becoming was a new process of identification, resulting in being Black in Britain, a change of self-recognition and emergence into visibility. Such processes are clearly part of the early experiences of the participants in this study.

The emerging racial self-awareness and self-recognition that developed in the process of identification for these women occurred in relation to white or 'Caucasian' others, who made up the majority in their new environment. These participants self-identified in various other ways, as Hall argued migrants do, but being immersed in a world of relationships with 'others' led to the manifestation of a previously inactive racial identity, that of Blackness. Rose buttresses this view when she talked about how Blackness '*started to surface'* in a worrying manner. These women began to be aware of becoming visibly different and of their minority status – being the

only Black person in the ward, or the only Black person in the whole GP surgery – and this new sense of racial awareness was accentuated by the significance, meanings, and representations of Blackness.

Understanding the significance, meanings, and representations of Blackness positioned the participants at the bottom of a hierarchy of racial identities. Several participants talked about learning to see themselves through other people's eyes as Black, and how this Blackness was generally symbolised as a negative factor. Participants' experiences tie in with a range of historical and contemporary research on racism. For example, Tsri (2016) argued that Blackness was depicted as inferior; Jordan (1974) discussed Blackness as being represented as evil, death, and debasement; and Fanon (1952) described the feelings of inadequacy and dependence that people with Black identities experience while residing in what he called 'a white world'. The findings of this study suggest that for my participants, these experiences were a constant in their working lives, with their credibility, integrity, and authenticity regularly questioned.

Following migration to the UK, being Black in Britain became a new, culturally salient and meaningful identity category as these participants were exposed to negative stereotypes and meanings of Blackness in their everyday lives by '*everybody'* (Anne, doctor). Being Black in the UK played a significant role in the process of becoming, but it was only a part of participants' 'hierarchy of experience' as they also had to negotiate a new work identity in the process, which I focus on in the section below.

5.2.4 Subordinate Theme Four: New Work Identities

Most of the participants migrated as highly skilled and/or qualified women (see demographic information in table 4.1). However, the work opportunities available to them on arriving in the UK were unskilled or semi-skilled job opportunities, meaning they worked in jobs that were not commensurate with their skills, experience and educational qualifications. This posed a threat to work identity of most of the participants, both nurses and doctors. The process of becoming in relation to their work identities was thus one of shock, destabilisation and challenge. Explored below are some of the participants' accounts of these experiences.

> "*For me it was a major culture shock. Again having worked in Nigeria, a young doctor, a pretty young doctor (laughs), at the time I had made my own money, and I had some level of independence and coming here and having no money and just being a number or statistic where nobody notices you, it was a bit difficult in the beginning, it was like a rude awakening … My first job in the UK even though I was a doctor was to deliver leaflets into people's houses, it was horrible*" (Jennifer, doctor)

Jennifer's search for job opportunities after migrating to the UK is characterised by a significant loss of a work identity. Previously holding several valued identity statuses related to her economic, gender and professional status, this financially independent, successful and attractive '*pretty young doctor'* is reduced to invisibility, becoming '*a number or statistic where nobody notices you'*. Her talk thus conveys a sense of loss, not just of status but of humanity or recognition ('*nobody notices you*'). Jennifer's process of becoming is a move from being someone to becoming no one, an emotionally destabilising moment. Jennifer describes going through a phase of culture shock, and a '*rude awakening'* as she experiences a mismatch

between her reality '*I was a doctor'*, and the '*horrible'* new reality in which '*my first job in the UK was to deliver leaflets into peoples' houses'*.

Jennifer's sense of self is related to her work; the kind of work she does and what it affords in terms of identity as well financial security and independence. The process of becoming in her migration to the UK, involving a shift from highly skilled to unskilled work, significantly destabilised her work identity and wider sense of self and value. A similar destabilising experience is described in the account below from Beverley, a doctor who described a loss of work identity as a result of a change in visa policy.

> "*When I came here [the UK] there were a lot of disappointments, I couldn't get work immediately … I was so unhappy, because I had left a good job back home, I was working in the National Hospital, it was a good job, I was well paid (…) I came and I was stuck, I couldn't work, I couldn't do anything because I was on a visitor visa and I couldn't change it to the other visa because it had been stopped, you know. It was just terrible, so I had to have a research post, unpaid research post … For a full year I didn't work, every day I woke up and I was like, who sent me to this place*?" (Beverley, doctor)

Beverley describes the process of becoming in the UK as characterised by a series of disappointments that made migration a miserable experience ('*I was so unhappy').* This unhappy experience is tied to her work identity, to her giving up '*a good job back home'* in medicine and the subsequent lack of employment opportunities for her on a visitor visa. Beverley describes the losses associated with the process of becoming a doctor in the UK, a range of challenges she encountered; she mentioned twice, '*I had a good job'*, '*it was a good job'*, her loss of earnings ('*well paid*') and a prestigious work identity in '*the National hospital'*. Disappointment follows as the psychological impact for one who had expectations of continued employment as a

successful doctor. Seeking a solution, Beverley takes what she sees as her only option, an unpaid research post. However, this is only partially addresses the problem. Frustrated at her lack of progress, being '*stuck'* and with a loss of income, she describes being unhappy about her situation and this unhappiness dominating her thoughts, since it's the first thing she thinks about, as she wakes up '*everyday'* for a '*full year'* questioning her situation.

Anne, another qualified doctor from Nigeria, also experienced downward mobility, stating that it was two years after immigrating before she got into a training post, one that she described as '*going below my standard',* suggesting a loss of status. The process of migration was thus devastating for these medical doctors, who were working in a globally recognised profession and suddenly had to face different employment options.

The deeply upsetting nature of losing their professional status demonstrated the salience and centrality of the doctors' work to their identity. However, the nurses also described difficulties in having to develop new work identities in their processes of migration and becoming. Most had worked in other occupations prior to migration to the UK, as in Cathryn's story, presented below.

> "*I was told a different ball game, and you have to start life from square one, from the scratch, regardless of what you've achieved back home (…) I studied Psychology before I came, and my dream was to be a Clinical Psychologist, but unfortunately when I came in here [the UK], I looked for jobs everywhere, and there was no experience for me (…) worked in a grocery shop, sorry, sandwich shop, Greggs (…) in that job for two and a half years I moved to another … I went into care … I was a catalogue distributor, e mm, I went from door to door, which I never imagined*" (Cathryn, nurse)

Cathryn uses metaphors *('a different ball game', 'start life from square one'*) to describe her experience of the UK labour market as inaccessible, and describes her loss as being '*regardless of what you've achieved back home*'; in her case, a qualification in psychology. Although Cathryn's migration was to reunite with her husband, she was also hopeful of 'becoming' a clinical psychologist in the UK. Instead, the reality she meets is described as a painful, disheartening transition where her hoped for ambitions are dashed. Her original career identity was no longer viable and the process of becoming meant '*starting from the scratch, regardless of what you've achieved back home'*, undertaking various low skilled jobs with such low status that they had been previously unimaginable ('*I went from door to door, which I never imagined'*). This signifies Cathryn's downward mobility; her new reality is a mismatch with her aspirations and expectations, and her dream of becoming a *'clinical psychologist'* is impossible as she negotiates a new work identity. Cathryn's process of becoming is marked by a loss of her sense of self.

Ursula, who also subsequently retrained as a nurse in the UK, similarly describes the process of migration and becoming as one of challenge and sacrifice in relation to employment identities and aspirations.

> "*I finished my degree in biochemistry (…) I was thinking like, I am going to get a job, make some money get back home … living in the UK is quite challenging because you make so much sacrifice, more or less you are outside your own comfort zone … especially if you like have a degree back home and things like that (…) you kind of have to do some courses, get used to the system, how it works and that will set you back a little bit*" (Ursula, nurse)

Despite her biochemistry degree, Ursula's expectation of successfully working in her chosen profession ('*I am going to get a job, make some money get back home')* was not realised. Instead she faced the challenges of having a new work identity, one that '*sets her back a little bit*' and which she described as '*challenging'* and a '*sacrifice'*. Ursula describes her situations as pushing her outside her '*comfort zone'*, alluding to discomfort. The process of migration in relation to employment opportunities is thus one of challenge and downward mobility ('*set you back a little bit'),* a destabilising reality far from expectation.

The painful nature of this destabilising experience was evident across participants' accounts. Vicky, now a mental health nurse, migrated with an undergraduate degree in food, science and technology, and a postgraduate degree in business administration, and described her lack of employment opportunities as "*like hitting walls*" and said that doing "*menial kind of work was what was available*" was "*disappointing*" and "*really disheartening*".

The two participants who migrated as a Nigerian-trained nurses also described difficulty in being able to build a continuous work identity between their lives in Nigeria and the UK. As Nina explained:

> "*I came as a staff nurse, I have been qualified since in 1997 in Nigeria, so I came to the UK in 2004 (…) Actually when I came to the UK, I struggled, I started with healthcare assistant*" (Nina, nurse)

Even though Nina came as a trained nurse from Nigeria, having a 'portable profession' was not sufficient in itself and initially she had to negotiate her work identity and work as a healthcare

assistant. The work available to her was thus semi-skilled, a far cry from her experience and qualifications in Nigeria. Thus for many of the participants in this study, the process of becoming was a downward shift from what they were, to what they would '*become*'; that is, unemployed, low skilled, unskilled and semi-skilled.

5.2.4.1 Summary of Subordinate Theme Four: New Work Identities

The process of becoming for these participants, in the context of forging a work identity in the UK, was marked by cultural shock at the temporal or permanent loss of self. Disappointment and frustration characterised participants' migration experiences as they became unemployed, unskilled, or semi-skilled on arrival in the UK.

Work identities provide aspects to a person's self-concept related to their organisational and occupational selves (Walsh & Gordon, 2008). An individual's work identity can be an important aspect of their personal identity, for both men and women, as expectations for women to be part of the paid workforce are normalised. This was the case for the participants in this study, whose work identities were an important part of their sense of self, affecting how they perceived themselves, and their sense of how others perceived them.

The participants encountered significant challenges in constructing a positive work identity commensurate with their qualifications, skills and experience after migrating to the UK, where

they were made to experience themselves as different and othered, with their overseas qualifications and experience unrecognised. Hall's (1996c) work on the process of becoming in relation to forming a work identity characterises identities as constantly in the process of change and transformation. The centrality of identity in such a major life transition as migration can be seen through this chapter, while the ways in which gendered and racialised identities affected the experiences of these women will be explored further in the conclusion of below, drawing on Hall's work on identity and the '*process of becoming*'.

5.3 Discussion and Conclusion of Chapter Five

This section explores how the above analysis can inform the research questions of this thesis. It also develops the chapter's analysis by contextualising it within the theoretical frameworks reviewed in chapter three, in particular using the lens of 'becoming' for conceptualising the emerging identities. The overall study includes a focus on the role professional status plays in mediating the gendered and racialised experiences of Nigerian women working in the NHS. However, many of the findings presented in this chapter show shared experiences across the nurse and doctor participants. Therefore, this section will focus on addressing the research question on the influence of gendered and racialised identities on participants' experiences, while recognising that not finding differences between doctors' and nurses' early experiences of migration demonstrates that professional status had little mediating effect on the experiences analysed in this chapter.

It is important therefore to note that the experiences described in this chapter were structured around the axis of gendered and racialised positionality. How might participants' experiences be understood or theorised in relation to Hall's concept of identity, which is about difference and representation as well as one's transformation and positionality in relation to others in the society in which one lives? Overall, this chapter contributes to an important but overlooked aspect of migration theory which, as shown in chapter 3, tends to focus on a single axis of differentiation rather than multiple social identities that locate individuals in multiple positionalities of privilege and/or of disadvantage.

The lived experiences of the 24 Nigerian women presented under the superordinate theme 'the process of becoming' discussed in this chapter showed similar gendered and racialised experiences. Through the analysis, these participants were found to be concerned with identity transitions while living and working in the UK. Hall and other cultural studies theorists use the '*process of becoming*' as a point of departure for thinking about identities from the point of 'being' to 'becoming' (McLeod & Yates, 2006), a process which was evident in the participants' sense making of their experiences. Given that the work of these cultural studies theorists on identity as 'becoming' is not usually empirical, this study offers a novel contribution by supporting Hall's theoretical framework as an important way to conceptualise migrant experiences. To develop this contribution further, below, I discuss in detail the four subordinate themes that make up the superordinate theme of 'process of becoming'.

Becoming a Nigerian woman in the UK: This first subordinate theme described the gendered experiences of the participants from a cross-cultural perspective as they moved from a

patriarchal to an egalitarian society. Cross-cultural migrations often present immigrants with gender-related challenges, with the renegotiation of gender-related roles a challenge of living in a new and different cultural environment (Suarez-Orozco & Qin, 2006). Dimitrov (2004) explains that gender relations differ between societies and that these differences can influence the adaptation of immigrant women in their destination country as they attempt to cope with cultural differences. Gender roles are culturally contingent, hence the variations across different cultures. The challenge for immigrants is thus whether or how much to adapt to their host country's gendered roles, in contrast to maintaining the gender roles of the origin culture (Berry, 2001; Meleis, 2010). Research also suggests that gender is particularly salient in the migrant experience of negotiations or renegotiations of gendered familial and spousal expectations and responsibilities, such as child-rearing responsibilities, husband-wife relations, parent-child relations and so on (Dion & Dion, 2001).

In line with the literature outlined above, a key aspect of the participants' transition experience in this study was from '*being*' a woman in Nigeria to '*becoming*' a Nigerian woman in the UK. That is, they experienced a shift from being positioned within known, cultural norms of female gender produced through a patriarchally organised society, to having to work out how to still '*do*' valued gendered practices in a context where Nigerian and UK gender roles were perceived as meaningfully different and as making contradictory demands on women.

In this context, participants encountered three key challenges. First, they had to take up new gendered roles while inhabiting old ones; second, these women had paid jobs while also doing

the domestic work for the family home, resulting in what Hochschild (2003) called '*the second shift*'; and third, they had to negotiate internalised cultural ideas of an ideal woman as supportive to the man, which problematised notions of female ambition and success in their own right, and thus their own career aspirations. Furthermore, agency was often withheld from these women. In Nigeria, the decision to emigrate was often made by the men in their lives, while the decision to gain paid employment in the UK was taken out of their hands by the economic realities of needing a dual-earner family income.

Drawing on the concept of culture shock, I propose that the differences in gender roles the participants' experienced, in effect, produced a '*gender shock*'. Gender shock was experienced when new ways of doing femininity and womanhood were required, in part because of cultural expectations, but also, as shown in the analysis, because of structural differences in the two countries' economies. Helen, for example, pointed to the need for *'everybody'* to work in the UK for familial survival. Sharon echoed her point, reiterating Hochschild's (2003) second shift argument, but understanding this not as the outcome of women entering the paid workforce as Hochschild argued, but as the outcome of an expectation in the UK for women to work, combined with a Nigerian cultural norm for women to take care of the domestic needs of the family.

Gender shock was experienced by both doctor and nurse participants, with doctors also reporting the second shift. Informing their process of becoming, gender shock opened up possibilities for

new ways of being women which were not easily integrated with internalised cultural gender norms from their home country, producing particular challenges for participants that were not easily overcome. The fragmentation and transformation of gendered identity utilised the resource of culture in their '*process of becoming*' (Hall, 1990; 1996c) since these women interpreted their gendered experiences as being differentiated by culture from other women in the UK. The fragmentation of these women's gendered identity was structured by the gender culture and status of being geographically located in the UK, thereby merging aspects of doing gender the Nigerian way and doing gender in the UK, by taking up paid employment. These women moved from a culture where they 'could' live as a housewife in a single-earning, male-breadwinner family structure, and migrated to a dual-earning family structure, a culture where 'everyone' had to work, and the money had to come from 'everywhere' as stated by Helen.

Becoming a migrant: In this second subordinate theme, participants learnt to understand themselves as being positioned within this dis-preferred identity. In chapter three, immigrant identities were reviewed on the basis of Hall's theory on identity and representation (1997c), which emphasised the positioning of identity through language, representation, and meanings. In the UK, the identities of immigrants are constructed as dis-preferred, categorised and 'othered' in various ways, for example, as 'unwanted outsiders' (Charteris-Black, 2006). However, there are a range of representations of immigrants, and positive positions are also available, leading to immigrants in the UK being categorised in dichotomous ways, for example, as the 'deserved' and 'undeserved', or the 'wanted' or 'unwanted' (Sales, 2002). As a result, there categories of

immigrants constructed as the desired and sought-after, and this categorisation impacts on how immigrants are viewed by the British public (Blinder & Allen, 2016b).

Economic contribution levels often determine the categorical representation of an immigrant. The categories of immigrants constructed as particularly problematic are done so through a discourse of 'burden'. The category constructed as the most desired is based on migrants' representation as contributing to the economy (Sales, 2002; Salter, 2003; Bhatia & Wallace, 2007). It is through this economic discourse that refugees, asylum seekers, and some economic immigrants are 'othered', with their presence represented in terms of a threat to housing, welfare system, and economic opportunities (Herbert, 2016). In contrast, those working in the healthcare sector, particularly doctors and nurses, are the most sought-after category of immigrants globally, since they are valued in terms of their ability to address worker shortages in the healthcare sector (Likupe, 2006; Blinder & Allen, 2016b). The participants in this study therefore had multiple positioning based on their migrant status through broader negative discourses of problematic immigration. This multiple positioning is in line with Hall's (1997a) view that the differential constructions and categorisations of identity mean that people are 'always positioned' in some way, yet never in the same social location, and consequently, different antagonisms can locate individuals in multiple positions of marginality and subordination.

Deaux (2006) makes a similar point, emphasising the need to consider the experience of the immigrant as a dynamic process which features a context – that is, social networks, opportunity structures and hostility or support from other groups – that affects the experiences of the

immigrant moving into a new society. In her analysis, Deaux (2006) highlighted how the social representation of immigrants acts as a key influence on those immigrants' experiences in their new environment. The experience of immigration is therefore not simply of an individual making sense of their place in the new society, but instead involves a new collective identity of 'migrant'. For example, witnessing or hearing about the experiences of other immigrants and exposure to the new society's cultural discourses and representations of immigrants provides the context through which immigrants make sense of themselves.

Deaux's (2006) arguments are supported by the analysis in this chapter, as representations and experiences of immigrants as 'other' had powerful effects on the participants. For example, Jennifer, a doctor, made sense of her immigrant identity based on her interpretation of how immigrants are perceived in the UK, '*where people are seen as migrants who have come to scoff off the system*' and '*a migrant who has come to bother their country, come to take off them'*. Jennifer's narrative depicts the negative imagery and social construction of immigrants as 'unwanted outsiders' with the potential to deplete the resources and wages of the indigenous members of society (Charteris-Black, 2006). In this story, all migrants are categorised the same, people here to exploit a health/welfare system, with the metaphorical 'scoff' producing a sense of over-consumption. This talk clearly constructs all immigrants as 'unwanted outsiders' (Charteris-Black, 2006), and was a dominant narrative in the participants' accounts of both their own and other migrants' experiences. This narrative dominated participants' experiences, so that professional status and healthcare worker status did not appear to make a difference to their stories, since the narrative was articulated across doctors' and nurses' accounts as well as across

the nurse participants who had migrated as nurses and those who had arrived with qualifications outside of the healthcare sector.

Hall (1997c) posits that language is used for meaning-making or to represent the world in a cultural context. Hall's view about representation, language and meaning is evident in the analysis of the participants' experiences above. The linguistic code 'immigrant', as understood by the participants, had negative connotations of being economic threats in relation to the indigenes, and viewed as incompetent, unwanted outsiders. These participants felt that their national identity and professional identity (such as medical doctor) were continually questioned because of their immigrant status. This occurred during interactions with patients, but also within the wider institution in which they worked (see discussion of the third subordinate theme below). Thus, the participants' immigrant identity was a symbolic representation that influenced their overall experiences in their working environment.

Becoming Black in Britain: In chapter three, the racial category 'Black' was discussed, drawing on Hall's (1997a) construct of the identity category 'Black' as a signifier, symbolically inscribed in the skin, marked as a colour, and constructed as a negative factor. I also discussed how Hall (1997a) conceptualised Black as a political, historical and cultural category, produced through colonial histories, culture and politics which are inscribed in the skin. For example, many of the participants in this study only 'became' – that is, experienced themselves as – Black when they moved to the UK, where being Black is a culturally salient and meaningful identity category. It is within this context that the participants of this study came to understand that they were 'Black' and what their 'Blackness' meant. As Rose said in the analysis above, being 'Black' created new

worries she had not experienced '*back home'* in Nigeria since it created both a new identity '*I'm Black, coloured'* and one that was very much in the minority '*you walk into a ward you are the only Black person'*. In this example, the racialised experiences of the participants were also shown to be embedded within the institutional and organisational practices and interpersonal processes that occur in everyday interactions at the participants' workplaces, which became reoccurring patterns of othering.

In Rose's words, being Black was thus a '*challenge'*. Similarly, becoming Black was an uncomfortable and difficult experience for most of the participants, particularly because it was related to negative representations of Blackness. The process of becoming involved moving into the awareness of a new identity of '*becoming*' Black in Britain and understanding the associated representations of this new identity.

New work identities: This fourth superordinate theme showed the centrality and salience of participants' work identities in structuring their sense of self and their experiences of migration, even though they might have enjoyed or sought to enjoy housewife status when in Nigeria.

As individuals make sense of their social environment, they locate a place for themselves and select identities that positively reinforce them, thus maintaining a sense of belonging (Ashforth & Kreiner, 1999; Walsh & Gordon, 2008). In the context of migrating to the UK with its dual-

earning family structure and a culture where '*everyone'* had to work, and the money had to come from '*everywhere'* (Helen), participants thus needed work that they valued as a vehicle to survive psychologically, socially, and economically. In addition, many participants had their own career aspirations that they expected migration to allow them to fulfil. However, participants did not find positive-reinforcing or esteem-enhancing work. Instead they described only having access to what might be through of as 'dirty work', conceptualised by Everett Hughes (1951) as tasks or occupations that are likely to be perceived as disgusting or degrading.

Accepting 'dirty work' not commensurate with their skills, qualifications, work experience or aspirations was part of the 'shock' of migration. Jennifer, for example, described having to distribute leaflets from door to door as part of the '*major cultural shock'* defining her migration experience. Jennifer's account illustrates how she perceived a diminished sense of self in what she had 'become', in her new work identity after 'being' a young, beautiful doctor. Vicky, who subsequently retrained as a nurse, also described the disappointing and disheartening experience of only having access to menial work, a far cry from her expectation and her search for managerial positions.

Summing up this discussion section, the IPA above showed how the participants' migration experience could be understood as a '*process of becoming*', characterised by a loss of self and any aspirational expectations for future possible selves, as participants came to understand themselves as being located in multiple ways as low status, particularly in relation to their

immigrant position, but also in relation to their racialised and gendered positions. The '*process of becoming*' was thus one of understanding of oneself as having dis-preferred identities, moving, for example, from '*pretty young doctor'* to a '*toxic'* immigrant faced with '*dead ends'*. This process of becoming was thus also characterised by shock and negative positioning.

Conclusion: Hall's theorising of migration as a process of becoming has shown to be a useful conceptual tool for this study, and was empirically supported by the analysis. However, I argue that Hall's theorising of identity is better served when it is explicitly linked with a feminist intersectional analysis, such as that informed by Crenshaw (1989, 1991; see chapter 3 for discussion on intersectionality). I make this argument because participants' gendered experiences at home suggest less of a becoming and more of a fixed identity that gets reproduced in the UK as it was in Nigeria. The difference being that while participants still had to perform their gendered roles as they did in Nigeria, in the UK they did this with less help and less time. This meant that the process of becoming was about learning to be Nigerian women living in the UK – that is, Nigerian women with fewer resources to undertake their traditional gender role. The analysis thus highlights how gendered Nigerian expectations remained, irrespective of additional and more time-consuming responsibilities produced by the host country's culture and economic structures. Overall, there was a clear pattern in which the immigration decision-making processes and experiences thereof were located within wider culturally specific gender norms and in interpersonal relationships that were informed by these gender norms.

Hall's theorising of the migrant identity as a process of becoming was also useful in making sense of participants' experiences of racialised identities. Indeed, what is most striking is how relevant his framework is, given that Hall was writing about migrant experiences in the late 20th century, between 20 to 40 years before the present study. Racialised identities – as migrants, Black people or Black migrants – impacted significantly on the participants' immigration experiences as they learnt to understand themselves in new and negative ways, having been positioned in dis-preferred categories of racialised people. Either the intersections of gender with their racialised experiences were not so evident to the participants, or these racialised experiences were not gendered, as the subthemes of becoming a migrant and becoming Black were rarely talked about as intersecting with gender, unlike the process of being Nigerian women in the UK at home.

The process of becoming a migrant or Black did, however, intersect with participants' employment experiences and opportunities, with the women experiencing the immigrational process of becoming as a series of shocks. These shocks were particularly felt in relation to their ability to gain valued employment. However, once employed as healthcare professionals in the NHS, the shocks continued through various processes of 'othering' that occurred in their organisations.

In starting the analysis chapters of this thesis with a focus on the processes of becoming as a migrant, chapter five showed how the participants had to negotiate a series of intensely felt

challenges around their gendered, racialised, migrant, and employment identities. Seeking to address these challenges, participants attempted to enhance their status by identifying routes to which they might gain access to valued work – work not considered 'dirty' or 'menial'– through which they might take up more valued identity positions. The analysis of how they made sense of these experiences is the focus of the following chapter.

CHAPTER 6 INEQUALITIES AT WORK

6.1 Introduction

Chapter five focused on the transitioning process of becoming a migrant in the UK, highlighting in particular participants' experiences of becoming 'Black' and a migrant, while learning to be a Nigerian woman living in the UK at home. Chapter five also showed how part of the experience of becoming Black was to experience limited work and training opportunities. Despite such barriers to employment, participants in this study ultimately secured employment in valued occupations as doctors or nurses. This chapter now focuses on their experiences as they established their careers in the NHS. It unveils the participants' experiences of inequalities produced through their positioning in relation to their gendered, racialised, and ethnic ascribed identities – that is, the way that other people in their workplaces responded to them as Black women migrants from Africa. As such, this chapter presents the multiple positions of marginality in which the participants found themselves, as well as the practices and processes that produced such inequalities at work. The section below introduces the superordinate theme and briefly describes the three subordinate themes (see table 6.1), the analysis of which is the focus of this chapter.

Superordinate themes	**Subordinate themes**
Inequalities at work	Disadvantaged in the labour market
	A squeeze before the top
	Work as challenging because of routine racism

Table 6.1 Table of Superordinate Theme Two

6.2 Superordinate Theme Two: Inequalities at Work

The second superordinate theme across the data set, '*inequalities at work'*, relates to participants' experiences of being 'othered' and disadvantaged on the grounds of their ascribed race/ethnicity, gender, and their immigrant status, as well as how these then structured their experiences at work. The superordinate theme focuses on '*inequalities at work'* because the participants made sense of their experiences through the lens of 'inequalities'. That is, they understood a range of practices at work, including opportunities for training and for promotion, as well as interactions with patients and colleagues and even from third parties such as law enforcement officers as being structured by discrimination that systematically disadvantaged them at work. Identity was central to their experiences of inequalities at work as participants described being responded to negatively because of their positionality in a range of dis-preferred identity categories including being Black, Black women and Black African/migrant women. Thus, although participants sometimes described racialised ascribed identities as intersecting with gender, it was their racialised identities that were experienced as the most salient in the range of employment practices, procedures and processes that participants understood to be discriminatory. These practices created additional work-related stress as the participants tried to 'prove themselves' under a hostile and untrusting gaze.

There are three subordinate themes underpinning the superordinate theme *'inequalities at work'*, and these are explored in the sections below. The subordinate themes are: (1) Disadvantaged in the labour market, (2) The squeeze before the top, and (3) Work as challenging because of routine racism.

Similar to chapter five, analysis of the three subordinate themes is brought together across the doctor and nurse participant data sets. This is because the IPA indicates that both doctor and nurse participants shared similar experiences of inequalities, of being disadvantaged while seeking employment and promotion, as well as in their day-to-day working lives and working relations with others. It was therefore important to show these overarching similarities, and as with chapter five, this shows how little professional status appeared to affect participants' experiences of inequalities at work that they associated with racism.

However, there were also some variations as to how the doctors and the nurses experienced each subordinate theme. Any differences found between the doctor and the nurse-participants are highlighted and discussed in the analysis to facilitate understanding. And, as with chapter five, at the end of the analysis of each subordinate theme, I develop the analysis through the relevant conceptual lenses discussed in the literature review. In this chapter, in particular, I draw on Acker's (2006) inequality regimes work, as well as Crenshaw's (1989) intersectionality, and the concepts of ascribed identifies (Linton, 1936). These analytical concepts are also used to develop the conclusion of this chapter, which draws together the analysis on inequalities at work with a view to exploring how these findings address the research questions of the thesis.

6.2.1 Subordinate Theme One: Disadvantaged in the Labour Market

This subordinate theme demonstrates the salient ascribed identities that contribute to participants' positionalities and structure their experience in the employment sector. There were

processes and practices which produced and reproduced inequalities for the participants in their work organisations. In some instances, inequality was brought about by a single identity category (for example Black), while in others, the experience of inequality was intersectional for participants (for example Black, woman migrant/African woman). Analysis starts below with examples of participants' experiences of seeking work in the NHS, before discussing their experiences as they sought new roles or training once employed in the organisation. The accounts highlight the experiences of disadvantage these participants had in accessing the labour market for employment opportunities, and the inequalities that continued as they sought to maintain their position or progress in the labour market.

As Nigerian migrants settling in the UK, finding suitable employment was a challenge common to these women. Participants endeavoured to establish themselves in the labour market and sought employment opportunities commensurate with their level of education, skills, and experience in the UK. Discriminatory processes and practices were experienced at this establishment stage of their career, entry into the UK labour market was challenging, and their ascribed identities which were constructed in the process of becoming, as described in chapter five, acted as barriers in participants' search for suitable job opportunities. The discriminatory employment practices and processes at the establishment stage will be the focus of this section.

Cathryn, a nurse-participant with an undergraduate degree in psychology from Nigeria, describes how she felt disadvantaged by her race intersecting with having an overseas qualification, resulting in discriminatory practices, despite regulations and rules.

> "*Already as a foreigner, a Black you are already disadvantaged. As a foreigner, you are a black, there is discrimination even though there are regulations and rules (…) especially having a qualification from a different country, it makes it very difficult for you to get jobs"* (Cathryn, nurse)

Cathryn identified herself as a foreigner, and as Black, indicating awareness of difference, of being visibly different in relation to others, and pointed out the impact this visible difference had on her chances of seeking employment opportunities in the UK. As new entrants into the UK labour market, Cathryn perceived that she was '*already*' disadvantaged by her racial identity and overseas qualification. In chapter five, Cathryn narrated her experience of having access to only unskilled and semi-skilled jobs such as working in Greggs, distributing magazines and working in a care establishment, a far cry from her aspiration to be a clinical psychologist. She indicates the subliminal influence of race, of difference ('*you are **already** disadvantaged*') on employment practices, *'especially'* as a result of having an overseas qualification. Cathryn also highlights the powerful influence of race which is such that equality initiatives ('*regulations and rules*') are circumvented and rendered ineffective in the recruitment process. Rose clearly sensed that racism has shaped her employment-seeking experience in the UK labour market; an unfair and discriminatory practice – institutional racism – which made it '*very difficult' for you [her] to get jobs*'.

Gail's account corroborates Cathryn's as she also indicates how her overseas-qualification and racialised positionality acted as barriers in securing a job in the UK labour market. However, she also includes her gendered identity and type of qualification as factors that unfavourably positioned her in the job market.

> *"I was searching vigorously for work, I used to analyse my CV, I said oh God, I have the toxic trio. Why do I call it the toxic trio? Toxic in the sense that these are the things that I feel are stopping me from getting a good job and it's basically three main things; I did my nursing back home which is in Africa, a Black man's land, that is one; I am a Black woman, that is two; and the third one, my nursing was a diploma*" (Gail, nurse)

In Gail's account, she describes '*searching vigorously for work*', which implies both significant effort and a lack of success despite that effort. Gail offers an explanation of what she recognises as the intersection of her ascribed identities (*'the toxic trio'*) – her gender, race, overseas qualification and work identity – that hinder her chances of securing *'a good job'* in the UK. Of this toxic trio, race and nationality are foregrounded, so that Gail's interpretation of the failure to meet her employment aspirations (*'stopping me from getting a good job'*) is structured by racism. Her emphasis on being stopped from getting '*a good job'* indicates that she gets access to some jobs but that these do not meet her standard of, and ambition for, '*a good job'*. In describing '*the toxic trio'* as stopping her from getting a good job, Gail shows that she has given this experience of racism some thought, going as far as to name it, and in the interview, calling the researcher's attention to it ('*Why do I call it the toxic trio?*'). Gail's experience of trying to establish herself in the labour market is thus characterised by unfairness and social exclusionary practises in the recruitment and hiring process. Her account of the '*toxic trio'* gives a sense of the impossibility of breaking through the institutional racism she felt was structuring her experience, positioning her as always inferior through her Blackness.

In the narrative below, Flora also describes her experience at the assessment stage of the recruitment and selection process as deeply racialised and notes the influence of 'white privilege'.

> *"If a white, Caucasian applies for a job, and if a Black (sister or brother) applies for the same job, you [the recruiter] have a duty to make sure you [the recruiter] support the Caucasian to get it (…) So when I come for that interview and the other person comes for the interview, even though I score 90 on your scoring sheet and she scores 70, you [the recruiter] are going to say, oh 70 is a good score, oh with appropriate support she will get there, you [the recruiter] will take her…"* (Flora, nurse)

In Flora's account, preferential treatment in the form of 'white privilege' functions across a range of experiences, and cuts across gendered experiences, since white privilege works at the detriment of Flora. For example, in the interview scenario she narrated, differential treatment based on race is used so that even where a Black person's performance is evaluated to be higher than a white candidate's performance, the white candidate is chosen with view to giving that candidate more support to improve their ability. Flora's story highlights a sense of the unfairness, since even with an objective measure by which the candidates can be contrasted, it will be the '*Caucasian to get it'*. Her rationale for this white privilege is presented in terms of a *'duty'* that recruiters have to 's*upport the Caucasian'*, to both provide them with employment and to give further support once in the post to compensate for their potential for poorer performance. This recruitment system is thus experienced as deeply oppressive, as recruiters must act in ways that maintain racism.

The experience is also one where Flora is the subject of discrimination, since there is slippage in the story, which moves from one about hypothetical others '*a white, Caucasian … a Black sister or brother'* to the story being about Flora herself '*even though I score 90 on your scoring sheet and she scores 70'*. In describing a scenario where Flora gets a much higher score than her subsequently employed white counterpart, she creates a sense of a personal experience of

inequality and the difficulties and material effects of being the 'dis-preferred' other in the face of white privilege. She also gives a sense of being part of a dis-preferred group of people – her Black brothers and sisters. As with Gail's extract above, Flora's account thus gives a profound sense of unfairness and of being faced with a structural racism that limits their ability to have agency and create employment opportunities for themselves.

The experience of discrimination in recruitment practices in the UK labour market is also evident in Sharon's extract below, where she shares her experience of being excluded through the intersections of her immigrant status and her nationality.

> "*Well there were jobs but I couldn't get one as a migrant, and I was told at some point that if they [the recruiters] can't get a British then they might consider my application*" (Sharon, nurse)

Sharon describes a labour market experience she had before she decided to retrain as a nurse. She describes knowing that there were jobs but being excluded from accessing them because of her position as a migrant. Sharon supports this standpoint with reference to another person who appears to work in recruitment, since they tell her that her application will only be considered if '*they can't get a British'.* The intersections of migrant status and nationality thus position her on some lower strata than '*a British'* person. Sharon therefore describes an experience of direct discrimination, as the recruiter specifically preferred to employ a British person. In her experience, selection is not based on competence or merit, but on preferential treatment of British people to her detriment as a non-British applicant.

Gail, Flora and Sharon were all nurse-participants, but both nurses and doctors shared experiences of unfair and discriminatory recruitment practices. Winnie and Quincy, for example, relayed accounts of their experiences in the recruitment and training structures for doctors and, as with the nurses, they pointed to the intersections of gender and migrant status as significantly structuring their access to opportunities and employment outcomes.

> "*As a migrant doctor in the UK … especially at the beginning, it is actually very difficult to get into the system (…) most of the indigenes are most likely to get into the two year roles especially at the beginning you have to fight for your six months' roles (…) you felt like you were losing a battle even though you were more qualified than those who get the jobs*" (Winnie, doctor)

> "*It was not easy to get on the training hierarchy in the hospital position. You are okay, it was designed in my opinion to be highly discriminatory, because you need to move on in the job every six months so you are forever applying and interviewing to get the next position*" (Quincy, doctor)

The experience of being 'dis-preferred' was one that structured the doctors' accounts of their training. Processing through the required training was '*very difficult*' and '*not easy*' for these doctor-participants, a difficulty attributed to discrimination, rather than any lack of skills, commitment or qualifications. This discrimination was experienced in a six-monthly cycle, creating the sense for Quincy at least that the system was explicitly organised to produce and reproduce discriminatory procedures, being '*designed… to be highly discriminatory*'. Winnie's migrant positionality also plays a significant role in shaping this experience of disadvantage, as she considers her need to apply every six months in comparison to her British counterparts who enjoy more continuous, uninterrupted training as they '*get into the two-year roles*'.

The unfairness of their experiences of discrimination were intensified for both the nurse and doctor participants, who experienced the use of English language requirements as a further structure designed to maintain white privilege, as in Mary and Gail's extracts below.

> "*With the European countries (…) even when they can't speak English, they do not have to do the sort of rigorous exams that I had to go through and some of my friends had to go through, well everybody that wants to practice as a medical doctor here that is not from Europe has to pass to enable them to practice as a doctor here. So, in that sense, that already creates a difference, and in that difference probably is not fair, because we studied in English with a British system that should enable you to practice … so already they don't waste time, doing that exam … in that sense they may progress faster than you*" (Mary, doctor)

> *"I did the IELTS. If you are trained in Africa, you need to do the IELTS exam. That is the International English Language Testing System … why would you need to test me on English language when I was trained in English language? They don't test their own students here in English language before they apply for a job, do they? Because they studied in English, so I see that as another barrier just to stop people or migrants from getting good chances or good shots at a good employment"* (Gail, nurse)

Both Gail and Mary talk about their experience of the requirement to undertake an English language test as being designed to disadvantage and discourage Black and African migrants. Thanks to their English language proficiency – in part an outcome of British colonial history in Nigeria – participants found the requirement to take an English language test because they were non-EU migrants frustrating. The test devalues Gail in terms of her past training and identification as an English speaker, but also reduces her (and other African migrants') work opportunities, since they are delayed in applying for jobs.

Despite the UK's colonial history with Nigeria, and its colonial legacy which includes contemporary doctors and nurses in Nigeria being trained in English, participants described having to take a test in the English language to access the labour market in the UK, even when EU migrants whose first language is not English were not tested. As such, the English language test is experienced as a discriminatory act and part of living with inequality regimes (Acker, 2006) based on being an African migrant. This is contrasted not only to EU-state citizens but also to British people ('*their own students'*) who, unfettered by English tests, can forge ahead. It is interesting to note how this phrase *'their own students'* further highlights a sense of in and out group. English language proficiency is often represented as a form of linguistic capital and should therefore have created a privileged position for Nigerian health sector workers in relation to other migrants, especially those from the EU (Harrison, 2013). Instead, the categorisation of African with migrant intersects in ways that are experienced as a barrier to accessing the '*good chances or good shots at a good employment'* opportunities.

In addition to race and migrant status, some participants felt that they were being disadvantaged due to their reproductive capacity as women. Like Gail's '*toxic trio'* above, Quincy describes triple dis-preferred positionalities of female migrant with a family.

> *"One felt disadvantaged by being a female, by being a migrant, and by having a family (…) it definitely did not help in the application or the job process, you probably discover that out of 50 applications you are given one reply, even at that you most likely will not get the job, but when their primary person declines then you are given an offer, so that you are never good enough as it were, to be chosen as the first person in an interview"* (Quincy, doctor)

Quincy mentions a number of recruitment practices that demonstrate her disadvantage: little or no response to job applications, receiving only one reply out of 50 applications; not being selected; and even when successful, this selection comes only after a more desirable applicant turned an offer down. She feels that her experience was racialised and gendered and that her status as a mother also worked against her. She does not attribute these experiences to a lack of skills or expertise, but rather to discriminatory disadvantage produced by the intersections of gender, migrant status and motherhood. Combined, these factors produce a profound sense of rejection ('*You are never good enough as it were to be chosen as the first person in an interview*') just as in the case of Sharon, who was told her application will be considered if no 'British' takes on the job. Jennifer, another doctor, also describes experiencing motherhood as disadvantageous and intersecting with racialised positionalities, as in her extract below.

> "W*omen are put in a place, because of the fear that these women are going to go on maternity leave, and yeah, so, it is not a hidden thing. If they were to employ another doctor, the first person that they would employ would be a middle-aged white man*" (Jennifer, doctor)

Like the other participants, Jennifer's experiences are gendered and racialised, but she also refers to age in her narrative. She is clear that it is her reproductive capacity that is feared (Gatrell, Cooper & Kossek, 2017) by the organisation, and that the preferred candidate for employment would be '*a middle-aged white man'.* Jennifer's account is supported by Beverley, who also refers to employers' fear of women's reproductive capacity, noting:

> *"Again, the bias against women also, some employers may feel a woman will get pregnant and leave with maternity pay…"* (Beverley, doctor)

Both Jennifer and Beverley point to women's reproductive capacity and maternity pay as motivating employers' discriminatory practices against women's recruitment. Interestingly, both

talk about an internalised/psychological framework in which women are problematised either subconsciously or not, in terms of finances. This is one of the few examples where there was a difference between doctors and nurses, perhaps because doctoring is traditionally a male job, meaning that the male body (the one that doesn't get pregnant) is the norm, and so female doctors are problematised because of their child-producing capacities. In contrast, nursing is a feminised job, and there is therefore less scrutiny of these participants' childbearing possibilities because it is more of a norm.

While professional status mediated discriminatory experiences based on childbearing, protecting the nurses more, this was a small difference in participants' overall narratives of disadvantage in entering their occupations. Both doctors and nurses revealed how recruitment and hiring practices, one of Acker's five core dimensions of her inequality regimes framework, led to them feeling consistently discriminated against and disadvantaged on the basis of their gender, their race and their migrant status. This will be further explored in the discussion section below.

6.2.1.1 Summary of Subordinate Theme One: Disadvantaged in the Labour Market

The analysis above highlights the shared experiences of the UK labour market for both the doctor and nurse participants in terms of feeling marginalised and describing discriminatory practices and processes as a result of their gendered, racialised, and migrant positionalities. In some cases, having an overseas qualification also shaped and structured their employment

experiences, while the doctor participants also noted employers' concerns over the 'extra' costs of maternity leave and pay as an additional factor limiting their equal access to employment.

Participants found some of the employment practices, procedures and processes discriminatory, as they were excluded from, or 'dis-preferred' for, the recruitment, selection, and career progression processes regardless of their qualifications, skills, experience, or length of service at work. Again, the general nature of work and informal interactions while doing that work produced and reinforced racial and gendered inequalities (Acker, 2006). In addition, participants' positioning as racialised, Black subjects, also had important effects on their workplace experiences even once they were established, as I discuss in the following section.

6.2.2 Subordinate Theme Two: A Squeeze before the Top: Not Getting Promoted

In this section, participants describe their experiences of hierarchical progression in their career and the effect their ascribed identity had on their career progression. They talk about the embeddedness of gender and racial discrimination in the organisational process and structure of career advancement, with Black people being under-represented at the top management level; participants also noted that the majority of people at the top were white. Participants discussed their experiences of exclusionary organisational practices and processes that often resulted in slower career progression because of their racial, migrant, or gendered identities, with some participants seeing this exclusion as the result of intersections of multiple dis-preferred identity categories. While the section above focused on participants' experiences as they entered and

established themselves in their healthcare careers, in this section I will focus on their accounts of their experiences of marginalisation and discrimination in the process of career advancement.

Below, Flora, one of the UK-trained nurses, reflects on the racial hierarchy entrenched in the career progression process in nursing and the experience of marginalisation that leaves Black women at the bottom of that racial hierarchy.

> "*If we see it as a triangle, where you have, everybody enters, then it starts to narrow up towards the top, as it squeezes up to the top, it squeezes out the Black women, and then you get to the top with the whites managing the base (…) everybody comes in at the base, then you are going up, it narrows and you tend to see less Black women …I can't see me getting to the top or making it in this profession (…) he's going to say I am not going to stick at it, I am going to leave and try something else, try another job, venture, try another area another profession (…) I am speaking from the black man perspective now … as a white male nurse, you are not feeling I am not going to make it here, those opportunities are not there for you or are there for you, you just branch in and go into management*". (Flora, nurse)

In this extract, Flora describes a hierarchical organisational structure, where everyone (Black and white) starts off from the same position ('*everyone comes in at the base*'), with fewer positions the higher up the organisation one goes. This organisational structure is given agency in her talk, since as it narrows towards the top, it '*squeezes out the Black women'* with the outcome that white people, both male and female, get the highest managerial positions. It also squeezes out the Black men but in a different manner from the Black women, as the Black men, seeing discrimination, are understood as having and making a choice to find alternative opportunities. Flora imagines the Black men saying, '*I am going to leave and try something else, try another job, venture, try another area another profession*'. This is contrasted to the white male nurse, who, untroubled by feelings of limited opportunities ('*you are not feeling I am not going to make*

it here, those opportunities are not there for you or are there for you'), can entertain ambitions for higher paid management jobs in the sector. Thus, although Flora is describing white privilege, she also understands men – whether Black or white – as having more agency than she who, as a Black woman, does not imagine leaving for better opportunities but does expect to be 'squeezed out' ('*I can't see me getting to the top or making it in this profession'*).

While Flora does not describe how discrimination occurs, her narrative account suggests the perception of direct discrimination against Black women, depicted by the repeated use of the word *'squeeze'*. The term '*squeeze'* indicates an active pressure to push out Black women that culminates in *'whites'* at the *'top'*. This both indicates discrimination against Black women and highlights the white privilege at work which participants experience as part of the organisational culture in which they work. For Flora, gender and race intersect, defining her experience of discrimination in the process of career progression and taking away hope for significant career aspirations. She is thus left feeling that she has few possibilities.

The doctors also discussed the role racialisation played in career progression, advantaging to their white colleagues and disadvantaging them as Blacks, corroborating Flora's account.

> *"They [senior people in her organisation] were mainly white and Asians, and you find that the higher you go the less Black and ethnic minority group that you see in those high positions (…) the medical profession is now becoming white administrative"* (Winnie, doctor)
>
> *"Very few senior people are Blacks; they may be mainly Asian or white, rarely Black"* (Rose, doctor)

The accounts of Rose and Winnie reveal the racial/ethnic hierarchy of senior positions, with both referring to white and/or Asian ethnic groups at the top, with the '*medical profession*' in Winnie's words, '*becoming white administrative*'. Winnie perceives that the Black and ethnic minorities are excluded from top management positions, and Rose reiterates Winnie's view of the racial/ethnic hierarchy of management that maintains racial privilege. This racial organisational structuring meant that the more successful the participants were; they were less likely to see other people like them in similar positions. This led to a sense of isolation. For example, Beverley, who considers herself to be at middle management level, confessed that *"it is lonely at the top"*.

The challenges produced by the participants' visible difference as Black women thus did not reduce as they reached more senior positions, which might otherwise have been experienced as bestowing authority and privilege. Irene, a nurse-participant who was also at middle management level, said *"it's even more challenging to try to stay at the top there, than to get there"*. Participants' direct experiences and observations of career progression were thus shaped by difference and a realisation that both career upward mobility and maintaining senior positions are difficult. In this sense, there was no respite *'no matter how high you go'*, according to Irene.

Participants often described being overlooked for training or promotion, a practice that appeared to be one of the ways in which Black women were 'squeezed out' of senior roles in the NHS. Below, for example, Sharon describes her experience of being disadvantaged in her pursuit of advancement and promotion at work.

> "*If there are like promotional courses going on they [white colleagues] want to have it done. And sometimes you get it from the managers, they promote the English ones, I am wanting to do a course, it is going to be very political there, because there are some English ones that have started way after me that are interested in the course*" (Sharon, nurse)

Sharon describes identifying a course she wants to do, but seeing barriers to her participation because '*managers ... promote the English ones'.* In this context, where both she and others want to access what appears to be a limited resource, the criteria for selection is one's nationality, rather than competence, readiness for promotion or length of service. This creates both an experience of inequality but also day-to-day difficulty with her interactions with her colleagues, since directly competing with other white staff is *'going to be political*'.

Irene also describes a personal experience of racial and ethnicity-based discrimination at work in terms of being repeatedly overlooked for promotion. She narrates how discriminatory promotional practices squeezed her out of the process, as she watches those she trained being '*promoted above me'*.

> "*I faced a lot of oppression because of my race, and my ethnicity. You are trained, you have the skills, you have the experience, you teach someone, but six months after the person comes into your job, the person is your boss …I have been in situations where I have been working in a role for two years and I'm training students and then the students qualify and within six months of qualifying as students, they are promoted above me. Even if I apply for the same roles with them, they get the promotion, I don't.*" (Irene, nurse)

Irene felt doubly disadvantaged, with her '*race and ... ethnicity'* creating '*a lot of oppression',* meaning she is unfairly treated at work. Irene feels a sense of exploitation at being qualified to

train new employees but not qualified to be promoted; this sense of exploitation was heightened by the promotion of her students '*above her*'. Her skills and experience were valued in terms of training others but undervalued and hence not enough for promotion due to her race and ethnicity. While she did not disclose the identity of those being trained, one gets a sense that the difference between her and those being trained is race- or ethnicity-related ('*I faced a lot of oppression because of my race and ethnicity*'), and that this perceived intersectional discrimination clearly mediated her experience and social reality at work.

Irene's story is one of frustration, hurt, and unfairness, as her two years of contribution and experience count for so little in comparison to the six months' work of her students who have been promoted above her. That this is a regular experience, shown in her reference to different examples (the person who becomes her 'boss', the students promoted above her), strengthens this feeling of frustration and unfairness and confirms to her that she is experiencing systematic racism. Eileen, also a nurse, narrates a similar personal experience of racial discrimination in the career progression process below.

> "*I was going up for a promotion … I really felt at the time it was basically due to my race, I wasn't given the same opportunity … apparently some of their people were being offered the same position, without even applying.*" (Eileen, nurse)

Eileen concludes that her failed attempt at promotion '*was basically due to my race'*. She comes to this conclusion because while she has to undergo a process of application for promotion (which was not successful), others do not. Indeed, her story is one where management disregarded the practice of job-related selection criteria altogether, offering the position to someone of their choice who was privileged enough not to need to undergo the application

process. Eileen indicated that this was a case of racial discrimination on the basis that her colleagues received preferential treatment to her detriment, as she states that she '*wasn't given the same opportunity*' and '*their people were being offered the same position, without even applying*'. In describing those who did get the position as being *'*their *people'*, Eileen shares an experience of them and us, whereby she is othered and made an outsider. By not giving her the same opportunity as others, she felt it was not an equal playground, and that the process had reinforced positions of subordination, resulting in a feeling of being 'othered'.

These feelings of experiencing systematic and repeated racially motivated disadvantage were shared across nurse and doctor participants. For example, like Irene, Anne described being excluded for promotion as a result of her immigrant identity. In Anne's case, this exclusion was from a GP partnership.

> "*Sometimes it is difficult as an immigrant to get partnerships, because that's just the way it is. They would rather give the partnerships to someone that is like them*" (Anne, doctor)

Partnerships offer opportunities for power, stability and the development of more accounting and managerial skills, but Anne feels excluded from accessing these resources because of her immigrant positionality. In the context where GP practice partners may '*give the partnership to'* anyone of their choice, Anne sees that usually these partnerships are given to *'someone that is like them*'. The criteria of their choice then are perceived to be on the basis of identity, in ways that exclude immigrants and favour indigenous GPs. Anne perceives this practice as discriminatory, excluding immigrants like herself from the process regardless of their

competence and/or suitability for the position. The outcome is that it is more '*difficult*' for her to progress in her career.

The ability for senior people to choose who they appoint to join them was also described as one of the processes that Black women get 'squeezed' out by Beverley, when she considered how hospital consultant positions are attained.

> "*A lot of the migrants were coming into training in some specialties, find that they stay in it for many years and they are not able to get to the peak, you know. They can't become consultants even though they have stayed many years in that field (…) when you finish your training to become a consultant, you have to be appointed to that, you know, so it is difficult, the appointments are usually for the people based here, the natives of this place*". (Beverley, doctor)

In medicine, consultant positions indicate advancement in a medical career. Beverley's experience is that these roles are allocated not on the basis of merit as read in the doctor's length of experience but rather through a selection process in the NHS that is characterised by entrenched discrimination. Beverley's observation that '*the appointments are usually for the people based here'* gives a sense of positions as being pre-allocated for British doctors. She also indicates that the bias against migrant candidates and preferential treatment of the indigenous candidates is typical in 'some specialties' and not others, which is an indication of unfair practices embedded in the organisation's career progression process. Again, Beverley noted a pattern of discrimination against migrant doctors at the appointment stage, as '*the appointments are usually for the people based here, the natives of this place*', indicating that appointment to consultant position was based on identity rather than on merit. Beverley's experience emphasised the '*many years*' of career stagnation these migrant doctors experience. These doctors are

capable, as they have undergone the training, yet are '*not able to get to the peak*', giving a deep sense of the unfairness of the situation she perceives and producing an understanding of the organisation, like Flora's earlier, of a triangle or mountain, the peak of which is not accessible for migrants, especially Black women migrants. Beverley thus perceives a serious barrier to the appointment of migrant doctors as consultants and consequently, to their career progression, creating a sense of not being able to fully participate or be valued in the organisation.

6.2.2.1 Summary of Subordinate Theme Two: Squeeze before the Top

The section above highlighted the experiences of the participants in terms of the practices and processes they experienced that created and maintained inequality in the organisations where they worked with regards to career progression. It also showed the central role that their identity positionalities played in excluding them in the career progression process and thus, shaping their career trajectory. As mentioned in an earlier chapter 5, migration for these women not only entails a change in geographic location, but also a social repositioning through a new process of identification, as ascribed and acquired identities, which can have a positive or negative influence on their experience. Participants described a variety of ways in which their racialised and migrant positionalities were responded to by others that squeezed Black, migrant-African women out of higher status jobs. I use the term 'identity positionalities' to highlight the way that these identities were ascribed by others, since participants described being treated by others as a result of these identity positions (see chapter 2, section 2.6 for a discussion on ascribed and

acquired identities). Participants did not, for example, describe identifying as lower status Black women and thus not applying for promotion. Instead, participants described repeated attempts at agentically moving through the organisational structure that were unsuccessful because they held identity positionalities dis-preferred by those making decisions about promotion.

In this section, race was the most salient identity. However, it also intersected with other identities such as gendered ones. Given that the racial, ethnic, and gendered identities of the doctors and nurses equally shaped their experiences of discrimination during the career progression process, it is further indicated that professional status did mediate their career progression experiences.

6.2.3 Subordinate Theme Three: Work as Challenging Because of Routine Racism

The third subordinate theme in this chapter focuses on the different ways in which the doctor and nurse participants found their work environment and work relationships challenging. Challenges that they attributed to their gendered, racialised, and migrant identities making them vulnerable. NHS Resolution data (BBC, 2017[3]) shows that the NHS is experiencing rising costs of litigation, with spending on clinical claims increasing every year since 2006/7 and being expected to increase further in the future. According to the National Audit Office, some trusts were spending up to 4% of their income on negligence claims. It is in this context that many of the doctor-

[3] https://www.bbc.co.uk/news/health-41180590

participants described feeling vulnerable to negligence claims, but these vulnerabilities were exasperated by racism.

The nurses also experienced feelings of vulnerability, although there were some differences between the doctors and the nurses. While doctors were concerned about litigation, the nurses were worried about being accused of molestation when touching the bodies of patients. However, in both of these aspects, the underlying racism was the same, in that participants feared unfair formal complaints aimed at them that were racially motivated, and described working in a context in which they worried about racially motivated scrutiny which was in itself was stressful. This vulnerability was because participants perceived themselves as being less likely to receive support from their employer in the event of such a claim being made against them, and perceived themselves as more likely than white British doctors to have such a claim made against them. Participants saw this double vulnerability as the result of their acquired positionalities due to their gendered, raced and ethnic identities. Anne describes this in her account:

> "*Because I am an immigrant, it is more likely that if I make a mistake at work, there will be higher litigation for me, do you understand? Because I am not from here, because I don't speak like them, so I have to be excellent*" (Anne, doctor)

Anne feels vulnerable as an immigrant doctor. She feels exposed and unprotected both because of her status as an immigrant and because she is linguistically different ('*I am an immigrant', 'I am not from here', 'I don't speak like them'*). Anne perceives her work to be more vulnerable to scrutiny than that of her colleagues; it is not simply about being good enough, but about being

'excellent' to avoid claims of negligence. This is echoed in Quincy's account of her experience before a '*fitness to practice'* panel:

> "*I have talked about working harder to avoid litigations because any litigation against you tends to be a bit more analysed than your indigenous counterpart. And also having had a bad experience of going before (what is it called?) the "medical fitness to practice" panel (…) being there at the "fitness to practice" panel you discovered that about eight doctors that were in the building on the day I was there that all of us were migrants, and with no indigenous persons (…) you had no defence really before the panel which I felt was because it was heavily laden against migrants*" (Quincy, doctor)

Quincy feels vulnerable in this fitness to practice panel due to her migrant status. It is interesting that she emphasises that amongst those doctors at work on the day the panel were there, '*all of us were migrants*' and that it was the absence of '*indigenous persons*' that meant they had no defence. She interprets this situation in terms of the panel being '*heavily laden against migrants*' who were without '*defence*', that is, the ability to defend themselves fairly. Due to this '*bad experience',* Quincy feels fearful of litigation and of her work being under more scrutiny because of her migrant status ('*more analysed than your indigenous counterpart')*. The outcome is that she has to work '*harder',* while also living with the anxiety of working in a system that does not give you a fair hearing because you are a migrant ('*you had no defence').* Below, Karen adds to the analysis, by showing how in her experience, it is the intersections of her acquired identities of being a Black woman and an immigrant that make her vulnerable.

> "*Being a Black woman, coming from a different country, and the way they litigate doctors, if you make any mistake you are out*" (Karen, doctor)

According to Karen, it is the intersections of being Black, a woman, a migrant and working in an organisational culture in which litigation occurs ('*the way they litigate doctors')* that make her

vulnerable. This vulnerability is intensely felt, since the consequences to female Black migrant doctors of litigation are severe, including losing one's livelihood ('*any mistake'* means *'you are out'*). Therefore, not only do female Black migrant doctors find it difficult to access positions in and be promoted within the NHS, their working lives are further marked by a constant sense of vulnerability from racially motivated higher levels of scrutiny that pose a real risk to their livelihoods.

The nurses also reported a sense of being scrutinised and vulnerable in a high-pressured environment. Below, Gail describes the kind of environment she works in.

> *"If you're fortunate, it's to find someone who sees you beyond your colour, and they see you for your experience and your hard work (…) Now if you have a patient, who is compos mentis complains that you didn't seek their consent before you did something to them, God help you, if they start to talk about their private bits, you are going to be, straightaway, tagged as someone who has sexually abused somebody else"* (Gail, nurse)

In Gail's account, her *'colour'* is something that '*if she is fortunate'* others may '*see beyond*'. Gail's *'colour'* or racialised identity is a wall or barrier for most people she works with or cares for. The skilled, experienced nurse is rendered invisible. Experience, hard work, and competence are discounted for Black nurses, in Gail's experience, making them vulnerable to the racism and whims of patients, as well as their power to complain. Like in the accounts of the doctors, here too is a sense that Gail is always vulnerable to losing her livelihood and is effectively defenceless (*'God help you'*). Working under such conditions creates added stress to the participants' working lives.

It is not just litigation or unfair complaints that immigrant doctors and nurses have to fear. For example, Karen describes other experiences with her patients that are marked by racism, particularly in relation to her immigrant identity.

> "*Being a migrant at work, sometimes you have the patients, you get the awkward patients, and they just tell you I don't want to see you, a foreign doctor, and sometimes some of the elderly patients make comments on your accent, like, oh you sound very foreign*" (Karen, doctor)

Karen discusses the '*awkward patients'* who reject medical consultation, not on the basis of incompetence but for one's immigrant identity. While Karen describes these patients as '*awkward'*, one guesses that it must be very difficult to be subjected to such blatant racism and rejection as well as to hear reminders of her difference and being othered by patients ('*Oh you sound very foreign*'). Indeed, in their talk, participants often downplayed the painfulness of their experience, which be interpreted as a strategy for being able to talk about those experiences (for further discussion of coping strategies, see chapter 7).

Anne shared similar experiences to Karen in terms of being 'visibly othered' by patients and colleagues.

> "*I don't want to see this Black doctor', I had situations that was the case (…) but what I found out was if you know your stuff, when they sit down with you, just a few minutes with you and they adjust their attitude towards you (…) Even with team members, erm, I found out that everybody has a stereotype in their mind as to how they think of someone who is a Black doctor, where are they coming from, you know, what country are they coming from, do they really know what they are doing"* (Anne, doctor)

Anne describes racist incidents with patients but crucially places the onus and burden of this racism on herself to convince those patients of her expertise and skill ('*What I found out was if you know your stuff, … they adjust their attitude towards you*'). Importantly, she feels this onus and burden to convince others that she is worthy of her professional status not just in relation to racist patients but also colleagues who question whether Black doctors from another country '*really know what they are doing'*. She appears to be empathising with those who subject her to racism at work, learning to understand how they think in order to convince them to change their mind. Anne does not appear to be aware of a different possible course of action, where perhaps rather than take responsibility for managing the racist attitudes directed towards her at work, she could hold her employer accountable to protect her as an employee from racist encounters.

The nurses also experienced racism at work while working with patients who did not want to be treated by them.

> *"I had an incident once, where this chap rang the bell, I responded to the call and he just looked at me and said please get me a British nurse (…) what he wanted was just someone to wipe his bottom (…) he buzzed again and another nurse came and I think she was Filipino and he looked at her and said, can you not get me another English nurse? There is no English nurse around, what do you want us to do, he eventually, reluctantly let one of us do it, you could see he was swearing*" (Sharon, nurse)

This is an account of racist encounter with a patient and two nurses. The patient did not talk to Sharon, he only looked at the colour of her skin and decided that she was not British and that he needed a British nurse to attend to him. The patient problematically conflates Britishness with whiteness, and both nurses seem to feel that they have no other recourse available to them but to engage with this patient. They do not make a complaint, they do not expect the employer to

protect them from the patient's racist views, rather they are then placed in the situation where they receive further abuse and '*swearing*' while wiping his bottom.

This patient's need did not require any specialised treatment or a complex procedure, but rather basic personal care, which any nurse can provide. This indicates that the motive of his prejudicial preference is not on the grounds of the incompetency of nurses who he thinks are not British, but just a refusal of contact with or care from nurses who he deems foreign. Despite the discriminatory request and offensive language (swearing) of the patient, both nurses carry on their duty of care towards him, but as they do so, they are made aware that they are 'other'. Not the 'angels' of the NHS, as nurses are sometimes framed, but deeply dis-preferred, not even worthy of wiping a man's bottom, from his perspective. In this context, where the patient only '*reluctantly'* lets them clean him, it is interesting to remember here Gail's account above where she points to the vulnerability she experienced around issues of consent and the need of patients for help with intimate bodily functions that require touching '*their private parts'*.

There were further experiences of racist othering that participants experienced at work, including that from third parties. In the account below, for example, Nina felt discriminated against by a police officer while she was at work.

> "*There was a patient who absconded (…) The police comes to my ward asking me my status instead of asking for the name of the patient that absconded, they were asking me about my immigration status, how did I come to this country, how long have I been here? I was so embarrassed wondering why they were asking me that. One of my colleagues had to come in (…) and my colleague said next time they ask you that don't answer them … I was so embarrassed, because I am Black, that is what the lady said. So why all that,*

> *if it is the white people they [the police] don't (…) it was a white police officer, and my colleague was white as well*" (Nina, nurse)

Nina describes her visible minority status ('*because I am Black*') as attracting the attention of the police. Her 'Blackness' makes her a person of whom to be suspicious, and so again, Nina is made to feel vulnerable because of her race. Gail, Karen and Quincy talk about vulnerability on the basis of their racialised position or their migrant status with regards to litigation and vulnerability with regards to experiencing racism as work. Nina's story is an example of an even more intense vulnerability since her entire status is put into question – is she even allowed to be here at all? – and here too, Nina is defenceless by herself but for the help of '*one of my colleagues (who) had to come in*'.

The police ask a series of questions, all of which work to position her as having an illegitimate status, and which creates powerful emotions in her. She is '*so embarrassed*' by this spotlight on her migrant status and constructs it as illegitimate '*wondering why they were asking me that'*. The rationale for these questions is then given by the other colleague, relating to her Nina's difference of being *'Black'*, with the colleague also confirming the illegitimacy of such questions ('*next time they ask you that don't answer them'*). This is an obvious case of direct discrimination, as pointed out by her white colleague. That race is salient to the participant is also evident when she describes both the police and her colleague as white, which is interpreted as conferring power to the colleague (since she is brought in to deal with the situation that Nina can no longer manage because of the police's actions) and to give the police further status that

undermines Nina through its racialised embodiment, that of a white police officer questioning a Black migrant.

Despite almost 23% of the British population being Black or ethnic minorities, the conflation of Blackness with non-Britishness creates a personal experience of racism for Nina and the other participants like Sharon, who describe having their colour of their skin read as a defining feature of their legitimacy. These experiences also create a sense that racism is systemic. Throughout the accounts in this section, it is clear that the participants share experiences of vulnerability to racism from patients and colleagues as well as third parties who may hold significant authority and, in Nina's case, who represent the state. Nina's is another story which offers a sense of how work is not a safe place for the participants. This is because a variety of people are able to question or reject participants' status as legitimate people and professionals through positioning them as a migrant and so they are 'othered' within a wider context of negative representations of migrants or Black people. This means that the participants experience themselves as enduring more checks than their non-migrant peers, such as the English tests as described in chapter five, or in Flora's extract below, which refers to phone calls to the home office.

> *"...as a migrant I feel limited, I feel I have to prove myself (...) it is only when you are a migrant that they have to phone the home office to ascertain that your indefinite leave is a true indefinite leave"* (Flora, Nurse).

Flora describes a discriminatory culture against migrants, leading to her feel that she has to '*prove*' herself in the workplace in similar ways to her doctor counterparts such as Quincy. She is made to '*feel limited'* because of her migrant identity, which means that phone calls to government offices are made when she goes to work. The system is such that it legitimises

racism and suspicion of migrants. This goes beyond organisational structures and inequality regimes at work (Acker, 2006) to include wider government institutions to which the NHS must comply.

Throughout this section, I have shown how the participants understand racism to be a key feature structuring their routine work, forcing them to prove themselves to a variety of people and in a variety of ways. Jennifer's extract below also describes the experience of needing to prove herself daily. However, for her, institutional racism also intersected with systemic sexism, which Jennifer notes her white counterparts also have to negotiate. Here then, out and in-groups blur, since Jennifer experiences herself as 'othered' through the colour of her skin since she is seen by patients and colleagues first as '*Black*', while also sharing similar experiences with '*colleagues who are Caucasian women'*. Through this comparison Jennifer concludes that it is '*more of a woman thing than a race thing'*.

> *I have to prove myself, that all eyes are on me, from the patients to my colleagues, oh she is Black, she is a fat, Black woman, the three negative (…) over the period of five to seven years that I have been here, my work and personality has proven itself, so I don't have to prove myself to them anymore … having said that, with my colleagues I always have to, on a daily basis, I have to be on par (…) colleagues of mine who are Caucasian women in the same working place, so knowing that they too have to prove themselves. So, I would want to say that is more of a woman thing than a race thing*" (Jennifer, doctor)

Interestingly, Jennifer notes that her body too is suspect and vulnerable not just because of her race and her gender but also because of its shape ('*oh she is Black, she is a fat, Black woman'*). This makes her visually different and results in the focus of others ('*all eyes are on me'*). Again, we have an experience of intense surveillance that makes a participant's working life more

challenging. Jennifer describes how she manages this surveillance and distrust, since over time, she feels she has proven herself through her '*work and personality*'. This individual solution gives her some relief (see chapter 7 for a further discussion of coping strategies). Up to this point, Jennifer's talk is similar to that already discussed. She experiences herself as othered through racialised positionality and the visible difference that locate her as a dis-preferred person. However, she then turns her attention (*'having said that'*) to considering her white female counterparts, noting that they have to employ the same strategy of proving themselves to others because they are women, which characterises Jennifer's doctor work space as male-dominated. In '*knowing that they too have to prove themselves*', Jennifer seems to get a sense of relief that she is not alone, which allows her to conclude it '*is more of a woman thing than a race thing*'.

The participants also discovered that part of being visibly different meant that they and their work faced more scrutiny than their white colleagues. For example, patients often reported being questioned in their ability to perform their jobs, such as in the extract below, where Nina narrates her experience of being scrutinised by patients, an experience that is described as a form of constant scrutiny, since such questions are asked of her '*all the time*'.

> *"…this is what I always experience all the time, like patients asking you where do you come from? How long have you been in this country? Are you sure you are good for the job? Are you sure you know what you are doing?"* (Nina, nurse)

Rose, a doctor, shared similar experiences, whereby she interprets her patients rejecting her expert opinion because she is Black:

> *"You are Black and there is a whole lot of difference (…) you tell people things they don't believe you…I had told someone something that was wrong with their child, and they didn't believe me, and the consultant came and told them exactly the same thing…you know they told me to my face, well they would like to seek second opinion"* (Rose, doctor)

In similar ways, most of the participants in this study noted their awareness of being visibly different from others after they migrated to the UK, and that their Blackness played a significant role in their overall labour market and organisational experience due to the negative connotations of being Black. For example, Beverley states:

> *"It is a disadvantage, it's just that idea of one coming from Africa, I am Black, you know, they think I don't know anything (…) it is a bit of shock for them to see a Black person (laughs), and then a Black doctor"* (Beverley, doctor)

Beverley perceives her being Black as putting her at a disadvantage, that her skin colour is read as a determinant of her intelligence and level of education, creating expectations of what occupations or jobs are best suited for her, and that being a doctor is not one of them. In Beverley's extract above, 'c*oming from Africa'* and being 'Black' are brought together, represented in the eyes of her white British patients as a category of people who '*don't know anything'.* By taking up a revered, knowledgeable professional status as a doctor, Beverly appears as an anomaly, leading to the shock she narrates that her patients experience when they come in contact with her in her professional capacity. Other doctors told similar stories. For example, Winnie described people looking surprised when realising she was a doctor, while Anne talked of patients wanting a different doctor. Both participants attributed this to wider discourses in which Blackness is associated with low levels of education and low status

occupations. In the extracts below, Flora and Irene add another dimension which informs their positionality as a Black person; that of slavery and servitude.

> *"The slave mentality, isn't it, because you are of a certain colour and this person is of a certain colour, then your roles are defined by that, because I am Black, I am going to be a housekeeper…kind of thing attitude…"* (Flora, nurse)

> *"…their expectations are different based on your colour, on your race… they think of it as servitude (…) when I come to them, I say, I'm the midwifery manager or I'm the nurse manager here, they don't understand that (…)"* (Irene, nurse)

Flora's explanation conforms to Hall's proposition about Black being a historical category, positioned in the context of the history of colonialism and of Black people in the present still living in the past as colonial subjects. Understanding Black people through the lens of slavery and servitude is presented in these extracts as structuring the contemporary work experiences of these nurses. By positioning the collective subject 'Black' within historical recruitment practices of 'slave' and 'master', these nurses are rendered unintelligible when taking up higher status roles such as nurse (compared to housekeeper) or manager (compared, it is implied, with the caring role of nurse).

Hall (1997a) argued that the histories of the Black people are inscribed in their skins. The perception of the participants narrated in the extracts above show a continuation of Blacks associated with slavery and servitude, where Black people can't be imagined in respected roles or expected to be good at their jobs, or able to produce high quality work, as evidenced by patients asking for second opinions after seeing a Black doctor, as well as the many other

encounters in the workplace described above. The associated negative connotations about being 'Black', including the representation of lacking in knowledge and the expectation of Blacks/Africans not to be high-achievers in Britain, create contrasting expectations to the realities of being treated by a Black doctor or seeing a Black nurse in a position of authority. Being Black and a doctor or a nurse manager are incongruent – low status and high status combine – which confuses expectations and leads to surprise, resistance (by asking for second opinion), exclusion, a lack of respect, and a profound sense of being 'other'. There were expectations of how nurses, who are caring and are not considered high-status, aligned with notions of African servitude and female nurturing, so that professional status was protective for them as they were congruent. In contrast, the Black women doctors had a high status role which confused expectation and was not protective for them. These extracts show how doctors and nurses reported similar experiences, where there are low-achieving expectations of their race or ethnicity. In this context, professional status was not a protective feature against inequality regimes.

6.2.3.1 Summary of Subordinate Theme Three: Work as Challenging because of Routine Racism

Both doctor and nurse participants found not just the work environment but also their working relationships with patients and colleagues challenging. Their experiences were marked by vulnerability to racism from patients and colleagues, as well as from third parties and through policies from the government. In some cases, participants' experiences were perceived as intersectional in nature.

This means that while there was an intersection between Black and immigrant status in participants' talk, such as in Nina's extract where her colleague pointed out that a line of questioning about her immigration status was based on her being 'Black', being Black held its own status as producing experience of inequalities.

Participants described seeing such white privilege, for example in what they saw as 'whites first' attitude in recruitment, and also in career progression opportunities. This leads to the next section, the discussion.

6.3 Discussion and Conclusion of Chapter Six

In a recent BBC documentary entitled 'Black is the new Black', Baroness Scotland shared her experience of speaking with a teacher who discouraged her from becoming a barrister after graduating as a law student, quoted as saying "these two impediments may be insurmountable […] the fact that you are Black and female" (BBC, 2016). While they are not insurmountable for either Baroness Scotland or the participants of this study, being Black women fundamentally structured participants' experiences of workplace inequalities.

Importantly, being Black intersected with participants' gender and immigrant status, which structured their experiences of working in the NHS, while their ethnicity and gender intersected

to structure their experiences at home. These identity categories – gender, immigrant status, Black – both semi-autonomously and in interaction with each other produced workplace inequalities, which sat alongside white privilege.

As discussed in chapter three, Acker (2006) highlighted the function that organisations play as 'critical locations' in the production and reproduction of inequality. She introduced the concept of 'inequality regimes' as an analytical approach to understanding the processes and practices that produce and maintain inequality in work organisations. Organisations are viewed as important locations for male dominance, where gendered processes interact with racialised processes to mutually shape the inequality experiences that occur (Acker, 2006). Male dominance is the direct result of the cultural expectations of organisational behaviours aligned to the representation of the man's body, sexuality and relationships, to biological differences and procreation, as well as paid work, particularly for white men (Acker, 1990; 2006).

Acker's inequality regimes (2006) highlights five organisational practices which (re)produce and maintain inequality in organisations. These include: (1) organising the general requirements of work, (2) organising class hierarchies, (3) recruitment and hiring, (4) wage setting and supervisory practices, and (5) informal interactions while 'doing' the work. These were discussed in more detail in chapter three (see section 3.4). These components and the different forms of direct, indirect, and internalised controls that occur in the five areas of organisational practice are understood as perpetuating inequalities in work organisations.

Acker (1990) stated that organisational hierarchies and inequality regimes in organisations are gendered, since traditional gendered notions of the unencumbered male worker create the context for men to be perceived as naturally suited for responsibility and authority, as they are understood as 'committed' to paid employment with little or no familial responsibilities to distract them. The gendered structure of some specialties in the medical profession, a long-standing male-dominated profession, shows that the structure and organisational setting of some specialties have been designed in ways that exclude those with familial responsibilities, particularly child care responsibilities, workers who are mainly women. For example, employment opportunities for women of reproductive age may be uncertain when employers fear pregnancy and the consequent need for maternity leave. Participants in this study described such issues, with gendered inequality against women being perceived as systemic. For example, Beverley, a doctor-participant, described the role of gender (in terms of fear of pregnancy) in relation to hiring and recruitment, Acker's (2006) third dimension of inequality. Jennifer's description in her extract above, uses the term *'subconsciously'*, which is also in line with Acker's (2006) notion of internalised forms of control within organisations which cannot be challenged; that is, a form of control that limits the opportunities of women with perceived procreation abilities.

On average, women are more likely to take career breaks to facilitate child rearing, making women statistically more likely to have familial responsibilities which are seen to 'cost' the organisation in time or money through parental leave, cover or pay. The statistical nature of this form of bias means that the focus is on the collective, thus whether or not a woman has a child

and/or takes a career break does not affect the bias toward women of child-bearing age. Women, even those who do not wish to have children, are subject to this form of discrimination.

The doctor-participants particularly experienced gender as structuring their work lives and opportunities. The characteristics of an ideal, unencumbered worker excludes women in work organisations (Acker, 2006) and as shown in the above analysis, this sense of exclusion spans across a range of practices along organisational inequalities regimes (Acker, 2006). This ideal was implied in participants' talk about the organisation of work in the NHS, facilitating the production, reproduction, and maintenance of gender inequalities. Gender was also experienced as a significant organising feature of workplace inequalities in its own right, although there was some talk of the intersections of gendered and racialised identities. At other points, participants narrated experiences of inequality based on their immigration status in the UK. Often these positionalities were experienced as intersectional, such as Gail's description of herself as 'a Black woman' and Quincy's quote, *"one felt disadvantaged by being a female, by being a migrant, and by having a family"*. Thus, while gendered, racialised and migrant identities were salient in terms of how participants experienced inequalities in the workplace, they also interacted. In particular, migrant identities often intersected, explicitly or implicitly, with racialised categories based on visible difference.

These experiences revealed the practices and processes that produced and maintained inequality for these participants while working in the NHS. The narratives demonstrate the visibility of inequality, and inequality regimes in the NHS, despite the fact that NHS is an equal opportunity

employer, revealing the disjunction between its written policies and the realities in existence. As a committed equal opportunities employer, the NHS might be assumed to be an equal playing field, but the experiences of these women highlight quite the opposite, as racism and sexism occur at multiple sites in the within the organisation. These inequality regimes also connect to Hall's concept of the process of becoming. The experiences of these women demonstrate how intersectionality can be a lens for looking at Hall's process of becoming work. Their experiences highlight the range of inequalities experienced at work, such as being disadvantaged in the labour market as well as affecting their career progression while employed in the NHS, and in particular the way that gendered, racialised and professional identities intersected in complex ways at work that were experienced as racist and sexist by the participants.

Acker's (2006) inequality regimes framework is also useful to help interpret these findings. When focusing on career progression, Acker highlighted the internal gender segregation she observed during a research project with a Swedish bank, where the assignment of strategic tasks to the male rather than the female employees was in the bid to groom these men for future managerial positions, to the detriment of the female staff. Parallels between the present study and Acker's work can be seen in the way that the preferred group (male for Acker, white British people in this study) were seen to be given opportunities to develop and thus increase their chances of career progression. However, in contradistinction to Acker's work, this study found that the role of race rather than gender was the basis for the inequality participants experienced while trying to advance their careers. For example, Sharon, a nurse, felt that her English colleagues were *'preferred'* for promotional courses.

The importance of racialised identities in career progression for health sector workers has also been highlighted by Oikelome and Healy (2007). Discussing the findings of the Committee for Racial Equality (CRE), they described that when comparing the career development of white and minority ethnic doctors with similar qualifications, overseas doctors took longer to receive promotions than their white counterparts (Oikelome & Healy, 2007). Recent research by the Royal College of Physicians (RCP) revealed racial discrimination against Black and minority ethnic doctors in the NHS's appointment process to consultant positions (Campbell, 2018). Findings indicated that in spite of fewer applications from white British doctors for consultant positions in comparison to their BME counterparts, there was a higher probability of white British doctors being shortlisted and offered a consultant job than BME doctors. These findings support Beverley's account of the career stagnation that migrant doctors experience in certain specialties in medicine, as they wait many years to be promoted.

The term employed by one of the participants when talking about the possibility of Black candidates at managerial levels – *'it squeezes up to the top, it squeezes out the Black women'* – gives the impression of a process that requires conscious effort and exerting of pressure to achieve the aim of squeezing out the Black women. In the accounts narrated, the women felt that white privilege resulted in them being *'squeezed out at the top'*. Again, applying the same processes and practices highlighted by Acker (2006), the above analysis demonstrates the inequality regimes that produced, maintained and continually reproduced inequality for these participants in their career progression.

Work was experienced as challenging due to the routine racism encountered by these participants, who felt vulnerable due to the manner in which their ascribed identities interacted in order to make their working environment and relationships challenging. Acker (2006) argued that racialised expectations are embedded in the use of different forms of control, and that the use of control is made possible by the existence of hierarchical organisational power. For Acker (2006), a route of direct control is through bureaucratic rules and differential punishments for breaking organisational rules, and Quincy's story of the risk of litigation is an example of this. In line with Acker's inequality regimes framework, litigation was a mechanism perceived by participants such as Quincy and Anne as a form of control, through which differential punishment was exerted. Other participants also talked about litigation as a mechanism of control. For example, Karen described how her fear of a litigation culture that discriminated against migrants made her work extra harder, since she feared losing her job and being without a source of income. This fear thus worked as an internalised form of control, which is invisible, unwritten, and thus cannot easily be challenged (Acker, 2006). Further examples of this are Quincy and Anne's solutions of avoiding litigation by working harder to 'prove' themselves. A recurring theme was therefore the need to do more to accommodate participants' devalued migrant positioning at work.

In line with understanding being Black as a political, historical and cultural category, Gilroy (1992) conceptualised race as a social and political resource used in contemporary Britain in the subordination and de-subordination of racialised subjects. Similarly, Palmer (2016) talked about the over-validation of white lives over Black lives within racialised power structures. In the UK, skin colour may impede access to certain organisations or institutions (Andrews, 2016).

The associated negative connotations about being 'Black', including representation of lacking in knowledge and the expectation of Blacks/Africans not to be high-achievers in Britain, create contrasting expectations to the realities of being treated by a Black doctor or a Black nurse in a position of authority. Being Black and a doctor or a nurse manager are incongruent – a combination of low and high status – which confuses expectations and leads to surprise, resistance (by asking for second opinion), exclusion, a lack of respect, and a profound sense of being 'othered'. However, as with Sharon's example, where a patient needed cleaning, sometimes nurses' low status did not protect them. These extracts show how doctors and nurses reported similar experiences, where there are low-achieving expectations of their race or ethnicity. In this context, professional status was not a consistently protective feature again inequality regimes.

Gilroy (1992) highlighted that racial power relations may not be explicit superiority and inferiority displays but can be subtle and elusive. Acker (2006) termed this the (in)visibility of inequality. Most participants perceived that the stereotype associated with 'Blackness' was negative, and that being Black meant to have a lower status associated with lack of knowledge or skill. In order to do their work, participants therefore had to resist this positioning, working *'extra'* hard to fit in, be included or respected. Professional status was not protective in this context, since both doctors and nurses, whether overseas-trained or UK-trained, had to go the extra mile to prove themselves, feel included and overcome racial discrimination.

Above, I have described how being a woman, Black, African or migrant could work to position participants into dis-preferred identities. While these categories were independently salient in the experiences that participants described, at other times they were also experienced as intersecting. The discussion on intersectionality in chapter three looked at the experience of discrimination occurring simultaneously as multiple identities interacted. In analysing the experiences of the respondents, an intersectional perspective requires an analysis of the interaction of how multiple identity categories might determine and define the experiences of these Black women. A particular concern is that Black women might experience double discrimination, as being both women (not men) and Black (not white) means that they do not have access to either white or male privilege (Crenshaw, 1989). Considering the intersections of racialised and gendered identities in the participants' experiences highlighted the way that participants often brought together their multiple locations into a single, dis-preferred position.

Participants interpreted their experiences as discrimination (and not, for example, a legitimate practice for new people entering a different system), in part because they experienced work-based practices that not only positioned them as 'other', but that also worked to privilege white people. Participants identified that racism was understood as creating racial differences in organisational hierarchies, but also described systematic white privilege. Thus, just as participants experienced being judged negatively for being immigrants and/or Black people, they also described white people being given opportunities and preferential treatment. Palmer (2016) talked about the over-validation of white lives over Black lives within racialised power structures. In such organisations, white workers experience privilege, for example, in preferential treatment in access to resources.

Conclusion

These findings address the research questions about the extent to which professional status mediated participants' experiences of living and working in the UK. Their experience was one of managing inequalities, little of which was alleviated with professional status. Professional status mediated the participants' experience of work-based sexism and racism; for example, Black female 'caring' nurses were more validated than Black female 'high status' doctors. Unlike the nurses, doctors' positionality was not congruent, with their low status Black and female positions being combined with high status as doctors meant they were treated in a range of ways that made them feel that they were not recognised as having a legitimate position within the organisation. At work, professional status thus mediated the effects of racism and sexism in ways that made it more likely for nurses, rather than doctors, to experience a sense of being valued.

Professional status mediated this in participants' labour market experiences but did not mediate their career progression experience or their experience of working in a challenging work environment, as doctors and nurses experienced a shared sense of vulnerability and threat to their livelihoods. This study has shown and supports the claim that doctors enjoy a better status globally, especially in comparison to other professions, including nursing, since the labour market outcome of doctors proved better in relation to the nurses, as they retained membership in the pre-migration profession unlike the like who acquired new work identities. The professional status of the doctors mediated their employment experiences, meaning that although most of the doctors experienced deskilling, they continued practicing in their desired profession of medicine.

However, that was not the case for the nurses. The professional status of the doctor-participants protected them against low status positioning associated with migration, in particular facilitating a positive negotiation of the dichotomy of deserving/undeserving migrant that is based on assessment of contribution to the host country. However, for many of the doctor participants, being a female Black migrant doctor meant they were positioned in incongruent ways that reduced their legitimacy to be doctors. In contrast, as long as they did not have aspirations to higher status roles within their profession, the congruence of being Black, female and in a valued 'caring' profession of nursing allowed the nurse participants to gain status both in the organisation and in their wider host culture. However, both doctors and nurses experienced an organisational culture structured around white privilege. The next chapter will explore ways in which the participants coped with discrimination in the NHS.

CHAPTER 7 COPING WITH THREATENING IDENTITIES

7.1 Introduction

Chapter five highlighted the experiences of emerging identities for the participants in the transitioning process of migration, and chapter six unveiled their experiences of inequalities at work. In these chapters, a set of patterns were identified in which participants described experiencing a range of inequalities and reduced opportunities based on their positioning along the intersections of being Black, female, and migrants from Africa. Most of the experiences at home and work were identity-threatening, as they often utilised negative stereotypes associated with participants' racialised, gendered, and immigrant identities in ways that were stressful, challenging, and in some cases potentially harmful. These experiences created significant stresses in the lives of participants, which were particularly experienced around employability, daily interactions at work, career progression, and domestic activities at home. This chapter focuses on exploring the strategies as well as the problem-based and emotion-based resources that the participants deployed to cope with the experiences which they found threatening to their identities, particularly in terms of coping with the demands of their new identities and responding to the discriminations and challenges experienced in the labour market and eventually at work. The section below introduces the superordinate theme further and briefly describes the three subordinate themes, the analysis of which is the focus of this chapter.

Superordinate theme	**Subordinate themes**
Coping with threatened identities	Navigating barriers to good employment
	Seeking out resources for managing the impossible
	Emotional strength

Table 7.1 Table of Superordinate Theme Three

7.2 Superordinate Theme Three : Coping with Threatened Identities

This third superordinate theme of the thesis, '*coping with threatened identities'*, describes the coping strategies deployed by the majority of the participants towards their perceived stressors, produced by being positioned in a range of dis-preferred identities. These strategies were used to manage participants' experiences of a racist and sexist organisational culture; interpersonal interactions at work; and the need to manage the 'second shift' produced through the expectation of fulfilling traditional gender roles as required of 'good' Nigerian women and mothers while also being in demanding paid employment. In some instances, coping strategies employed by doctor and nurse participants varied. For example, nurses and doctors used different strategies for accessing the labour market, with the nurses acquiring a status through professional training, while the doctors chose professional specialties or geographic locations to work in that were less desirable and thus reduced the amount of competition they had with their white and British peers. Other coping strategies were described by both doctor and nurse participants, such as trying to 'work harder' than their white counterparts to prove their worth and outsourcing their childcare (but not domestic) responsibilities.

The solutions participants described mapped onto two categories of stress responses discussed in psychological literature, namely problem-based and emotion-based solutions. In the context of this study, emotional solutions were employed to manage the emotions participants experienced in stressful situations. These strategies involved managing their emotions so that they were less emotionally reactive; reaching out for social support; or drawing on a sense of resilience and

strength through religious belief. In contrast, other solutions involved targeting the problem or stressful situation in a practical way, and so can be interpreted as problem-based. For example, repositioning, conscious positioning and confrontation.

These strategies were evident in the three subordinate themes that underpin the superordinate theme of '*coping with threatened identities*', which are: (1) Navigating barriers to good employment (2) Seeking out resources for managing the impossible and (3) Emotional strength. These subordinate themes, which enable an understanding of participants' experiences of managing their stressors, are explored below.

7.2.1 Subordinate Theme One: Navigating Barriers to Good Employment

As discussed in chapter six, the doctor and nurse participants found themselves in multiple positions of marginality and experienced barriers to employment in the UK that led to limited work and training opportunities. However, while they shared the common experience of barriers to employment, doctors and nurses had differential experiences in the labour market post-migration. Nine of the 12 nurse-participants migrated to the UK in other occupations, and only resorted to nursing when their ascribed identities posed a threat to their work identity. Two of these three were Nigerian-trained nurses, one of whom gained entry into the nursing profession in the UK after an adaptation course, while the other assessed her overseas nursing diploma training as a hindrance in the UK and so acquired a British nursing degree. The third nurse migrated as a fresher and also acquired a UK nursing degree. On the other hand, 10 of the 12 doctor-participants migrated as Nigerian-trained doctors and had to complete post-graduate and

specialist trainings to enable them practice as doctors in the UK. These doctors experienced barriers in terms of the English language tests they had to take in order to practice, and experienced being the dis-preferred candidates during trainings.

These differences led to the doctor and nurse participants deploying different coping strategies to cope with the difficulties experienced in accessing what they considered to be 'good' employment. These strategies will be explored in the section below.

7.2.1.1 Repositioning (Nurses)

Ten of the 12 nurses came into the UK in occupations other than nursing and originally aspired to advance their career in these occupations. However, they found themselves only able to access unskilled and semi-skilled jobs, and so came to consider training in nursing as a way out of their precarious employment situation.

For Sharon, the choice of nursing as a career was a coping strategy utilised to navigate her way out the unemployment she found herself in as a result of her migrant and non-British identity.

> *"I originally came as a student, to do my Masters in business administration, there weren't jobs in that, well there were jobs but I couldn't get one as a migrant, and I was told at some point that if they [the recruiters] can't get a British, then they might consider my application, so that made me change my profession and I went to train as a nurse in the University… I went into nursing because I couldn't get a job in the other field where I had wanted to aspire well in, so when I went into nursing I didn't look for the job, the job came to me"* (Sharon, nurse)

Although a part of this extract was discussed briefly in chapter six in relation to the subordinate theme 'Disadvantaged in the labour market', this more detailed extract gives context about the coping mechanism Sharon employed to deal with the discrimination she experienced as a migrant in the UK labour market. Sharon assessed her unemployment situation as an identity-threatening situation, as she indicated in chapter six by saying she '*couldn't get one as a migrant*'. She sees her migrant status as limiting her access to the labour market, at least in terms of where she '*wanted to aspire [to do] well',* and perceives discrimination in the way she is excluded as a non-British candidate in the process. Sharon also senses there is a status hierarchy, whereby the criteria for making a hiring decision is evaluated through her ascribed immigrant and non-British statuses, and that these identities are understood as being of less value than those of the British candidates. Not being British thus not only produces identity threatening experiences, but also hinders Sharon's employment opportunities. The challenge of becoming employed as a migrant, even after securing a postgraduate qualification in business management, left Sharon feeling vulnerable enough in the labour market that she made a significant career transition from management to nursing. Sharon recognised the threat that her ascribed migrant status posed and, considering that her migrant identity was unchangeable, she sought to modify her employment opportunities by developing new skills as well as a professional identity in which her migrant and non-British identities were less of a threat.

Sharon's solution was therefore to seek a profession that would accept her, and which, while not necessarily her original area of interest, was good enough to want to *'aspire [to do] well in'*. The outcome is that despite finding an agentic strategy to her employment problem that involved identifying a profession she could enter and retraining for it, she describes her entry into nursing

in relatively passive terms, saying *'the job came to me'*. This also meant that for Sharon, and many of the other nurse participants, nursing was originally conceived of as a profession unstructured by racial discrimination.

In the extract below, Irene confirms the perception of nursing as a direction that offered hope in terms of employment opportunities in the UK.

> *"I came as a student. I came on a student visa (…) after one year of studying at Master's degree level, I decided to go into the healthcare profession. So I started from the beginning, trained as a nurse, then I went on and trained as a midwife (…) there was still need for migrants in the field of health care (…) starting from the beginning to train and retrain"* (Irene, nurse)

In this short extract, Irene describes changing direction after her postgraduate studies in the UK, re-starting by training as a nurse, and indicates the disappointment she felt by saying '*starting from the beginning*'. Irene then describes undertaking specialised training as a midwife. She attributes the opportunities for her doing this training in terms of her migrant identity '*there was still need for migrants in the field of healthcare*'. Like Sharon, Irene's interpretation of her entrance into nursing illustrates the problematic nature of the ascribed status of the immigrant identity in accessing the UK labour market. She assessed the labour market in the context of its identity-threatening problem, and responded to the challenge, necessitating the strategy of acquiring a new professional identity. This new professional identity was only available to her because of labour market shortages, meaning there was a '*need for migrants'*. Nursing is only available to Irene because, as Sharon might have put it, they cannot get '*a British'*.

While the experience of this retraining was in some ways diminishing, experienced as a backward and repetitive step (‘*starting from the beginning to train and retrain’*), it also shows how Sharon and Irene employed a problem-based approach in response to their situation. They identify the external problem (racial discrimination limiting their employment prospects) and then seek to find a solution in an external resource available at their disposal, in this case retraining opportunities in nursing. Changing profession thus allowed these participants to enhance their status.

This problem-based solution of retraining as a nurse was also taken by Cathryn. However, while Sharon and Irene retrained as nurses after studying in the UK as could not access employment opportunities in their initially chosen fields, Cathryn saw nursing as a route out of unskilled and semi-skilled employment to a highly skilled employment situation.

> *“I was distributing catalogues … I went into care work, and I was a carer for about 18 months before I moved on again to go into college… I studied psychology before I came, and my dream was to be a clinical psychologist, but unfortunately when I came in here, I looked for jobs everywhere, and there was no experience for me so it was nursing for me”* (Cathryn, nurse)

A part of this extract was used in chapter five to illustrate the downward mobility Cathryn experienced post-migration in the UK. The extended quote here is used to give context to the coping strategy Cathryn employed in response to her employment situation in the UK. As a graduate with aspirations for a career in clinical psychology, Cathryn arrives in the UK to find that the only work available to her is low and semi-skilled, distributing catalogues and care work.

She states that she '*looked for jobs everywhere*', but that this significant effort is unrewarded. Left with only with care work as an option, she retrains to be a nurse.

Cathryn's assessment of the value of the unskilled and semiskilled work, despite being highly skilled with a qualification in psychology and an aspiration to be a clinical psychologist, led to feelings of frustration and disappointment. Her disappointment is illustrated through her use of the word '*unfortunately*', which refers to the employment situation she met in the UK, the movement from one unskilled job to the other and the time frame involved. Cathryn's choice of nursing as an alternative career path is a compromise to salvage her status and continuity in the once-known path of the 'highly skilled'. As with the other participants so far discussed in this chapter, Cathryn assessed nursing as an available option for reclaiming her professional identity and repositioning her occupational status, and by association, repositioning herself. While Cathryn did not expressly state her perception of a status loss, she implicitly indicated her search for a 'status enhancer', since remaining a carer is not considered an option.

Gail is one of the two nurse participants who migrated from Nigeria as nurses, yet she also pursued a nursing degree from a UK university as a status enhancer.

> *"Before I start putting myself through hell, let me improve my chances, so I went back to the University (…) Now I have my degree"* (Gail, nurse)

In the above extract, Gail engages in higher level nurse training as a way to address what she considers to be a set of problematic positionalities that reduce her employment prospects. This

training was the outcome of Gail's self-evaluation of her employment circumstance, discussed in chapter six, revealing some dis-preferred positionalities which posed as potentials threats to '*getting a good job*'. These dis-preferred positionalities were described in terms of a *'toxic trio'* intersectional positionality of having a qualification from Africa, being a black woman and having a nursing diploma rather than a degree (see chapter six for analysis of the 'toxic trio'). Here, we see further that Gail's analysis of her 'toxic trio' positionality is that it is a significant threat. She is in danger of '*putting myself through hell'*, an analysis which leads her to identify a route to '*improve my chances, so I went back to the University… Now I have my degree'*. Gail's assessment of her positionality in the labour market has led to her appraisal of a UK nursing degree as an external resource which can counter these threats to her ascribed and acquired characteristics, thus enhancing her acquired status.

There were also practical reasons for going into nursing, since as Linda says below, nursing offered a salary that allowed participants to '*pay their bills*'.

> *"Most Nigerians in nursing do not actually go into nursing as a first career choice (…) when they come into this country, they then choose to do nursing (…) what they are looking at is, their salary, the position is secondary. Their salary is the most important thing, as long as they are able to pay their bills."* (Linda, nurse)

The choice of nursing as a profession by these participants can be considered in the context of status difference between countries and continents. Not only was nursing an option open to migrants in the UK, it also offered a higher status than in Nigeria.

> *"there is a stigma to nursing back in Africa, nursing is not really a well-learned and trained profession, so I thought I'd go into medicine, but when I came to England I was a*

> *bit older, so going into university, it was a bit of restriction, I was just not advised properly, as I thought going into medicine maybe a bit difficult, I had just turned 21, so I decided, ah, I wanted nursing"* (Eileen, nurse)

Linda and Eileen's extracts contextualise nursing as a conditional career choice for Nigerians after they migrate to the UK, especially when their aspired careers or incomes fail to materialise. Eileen also explains that the social representation of nursing in Nigeria is fundamentally negative while it is positively valued in the UK, meaning it becomes a valid career choice for Nigerian people based in the UK seeking good employment. In Eileen's extract there is a sense of loss, since her aspirations to medicine fail not from her own volition or ability, but due to external considerations of age and poor advice (*'I was just not advised properly')*. However, nursing also provides new and previously unconsidered career opportunities for Eileen and many of the other participants, such as Flora, Helen, Linda, and Cathryn. Nursing thus offers a way of navigating through the barriers of the job market, providing status and a good job.

In the section below, I now turn to the coping strategies employed by the doctors, 10 of whom migrated as members of an internationally recognised profession and were able to remain in that profession (albeit with further training).

7.2.1.2 Conscious Positioning (Doctors): Specialism

Many of the doctors interviewed were working in general practice, which they perceived as an area of medicine that enabled them to work while meeting their family responsibilities, and which they associated with being a woman, as Pippa and Anne explain below.

> *"For a job like general practice, your gender is an advantage (…) So in general practice you find many practices are looking for female doctors (…) in other specialities like surgery for example, I find women complain about the hours, with family life it is not really good for one (…) For me I chose to be a GP because of that, initially I thought I was going to be a surgeon, but the hours were so difficult with home so I chose to be a GP"* (Pippa, doctor)

> *"I started off doing obstetrics and gynaecology, then along the way I found out this is going to be so stressful for me and my family, so I better do general practice (…) initially I was in obstetrics and gynaecology, and then I found out that it was very time consuming. I never had time for my children"* (Anne, doctor)

Pippa and Anne started off working in specialties such surgery or obstetrics and gynaecology. However, as women with families, they recognised the time constraints (*'it was very time consuming'*) in such specialties as inhibiting to having a work-life balance. These women consciously and successfully navigated a career path into general practice as a solution to the gendered organisation of work (*'I find women complain about the hours'*) in surgery, obstetrics and gynaecology, and away from specialties where they were emerged as dis-preferred identities. Pippa interprets this as a gender issue which is not intersectional; she sees it as a bond across women regardless of race.

Decisions around specialisms were a conscious positioning that allowed participants to continually practice medicine, albeit in specialties other than their desired choices, in a manner that shows compliance with gender expectations. General practice provided the flexibility around these expectations, keeping a balance.

It is important to note that these participants do not describe their domestic responsibilities as the problem. Pippa talks about wanting time for her '*family life'* and Anne about wanting a job that allowed her to have *'time for my children'*. Their interpretation of their experiences thus suggests that some areas of medicine are incompatible for women who are also taking up normative roles of mothers who have time for their children.

Pippa further explained that in general practice, her gender was an advantage, saying: '*in general practice you find many practices are looking for female doctors'*. The move to general practice thus allowed her to be positioned as having value because of her sex, thus increasing her chances of employment in an occupational context where she might otherwise experience discriminatory barriers. Thus, as with the nurses in the section above, these doctors used a problem-based strategy, in this case identifying where their structural positioning as women might be valued and provide them, in their process of becoming, with more of an 'insider' status.

Similar to Pippa and Anne, many of the doctor participants perceived that their positionality as women with normative family responsibilities structured their career trajectories, which suggests a shared positionality across female doctors regardless of their racialised identities. However,

Quincy offers a different interpretation below, arguing that at more senior levels, discriminatory recruitment processes occur at the intersections of racialised and gendered identities. Thus, Quincy's experience differs from that of Pippa and Anne since her switch to general practice was not only due to the flexibility and work-family balance it provided, but also because she envisaged a potential challenge to career progression as a female migrant doctor.

> *"I have been involved in two fields of specialisation in medicine, the first was obstetrics and gynaecology (…) Coming out here with that specialty where the original reasons for choosing that specialty were no longer obtainable, so I made a decision to switch to general practice, which was primarily to help me meet my family obligations (…) the training hierarchy in the hospital position, it was designed in my opinion to be highly discriminatory, because you need to move on in the job every six months so you are forever applying and interviewing to get the next position, but that seemed to heap up more, eight times more against you once you reach the registrar position… Because to get beyond that, to the higher post, the senior registrar and the consultant post is virtually impossible as a migrant and as a female. And that also was part of my decision to move into general practice"* (Quincy, doctor)

This extract builds on the analysis of Quincy's experience in chapter six in terms of the additional discrimination perceived in the obstetrics and gynaecology/hospital setting. In this more extended extract, the coping mechanism Quincy employed to negotiate the barriers is shown.

Quincy's extract starts with her stating that it was her decision to make the switch between specialties, indicating her agency, as she reviews the barriers of the specialty and its impact on her duties as a mother. Quincy identifies general practice as a barrier-navigating strategy for migrant female doctors, based on her review of what she recognised as limited career progression opportunities or possibilities in a '*highly discriminatory*' work culture, which in

effect would take decisions from her. By referring to her previously desired situation as '*virtually impossible*', Quincy indicates that acceptance that the lack of continuity in that specialty would have hindered her career progression opportunities. This impossibility is also directly linked to Quincy's multiple location at the intersections of gender and migrant status, since it '*is virtually impossible as a migrant and as a female*', highlighting the threat her migrant status and gender pose to her career progression. Quincy feels that the interaction of her migrant status and gender status meant her career progression in obstetrics and gynaecology would be a challenge and would have an impact on her family life and responsibilities. Again, Quincy identifies family commitments as another factor for the switch, and employs working in general practice as a strategy for a successful work-life balance and to enable career progression.

General practice was not the only specialty accommodating participants' need to be able to negotiate the occupational barriers they experienced as women with a family life and/or as Black/migrant women negotiating racist organisational cultures. Psychiatry and paediatrics were also mentioned as specialties in which Black migrants could succeed as these were understood to be less desirable specialities for their white counterparts and thus there was less competition with them, as described by Rose:

> *"Paediatrics is not a field that's white-dominated, so not many whites want to do it, so it also helped, you know for me… but if I wanted to go into a very competitive field I doubt if I would have had that opportunity (…) Even in general practice because there is a decline now in, you know, British-trained doctors are not going there, there are vacancies so my friends are all finding it very easy to get a job in general practice."*
> (Rose, doctor)

In this extract, and in others from the doctor participants on the conscious positionality of specialty, what emerges are descriptions of strategic solutions for navigating into and coping with specialties in which race is less of a threat to being able to compete. Rose highlights the choice of specialties her 'whites' counterparts have ('*not many whites want to do it'*), leaving the less desirable specialities to Black doctors like her. This limits Rose as she does not have the same level of choice as her white peers, but her discussion of her strategy to find a place in medicine where she might be recognised and given access and opportunities ('*so it also helped, you know for me')* is also an indication of contending with her fate and finding satisfaction in having identified a niche in medicine in the UK for herself. Rose also acknowledges the demand in general practice for doctors, and says that her friends who are not British-trained are *'finding it very easy to get a job in general practice',* supporting the view of general practice as the less attractive specialty for the whites and British-trained doctors and so giving foreign-trained and Black doctors opportunities to practice medicine in the UK.

The privilege of white, male British and British-trained doctors thus structures the possibilities for those who are Black, female, migrant or, as Jennifer argues below, '*foreign-trained'*. In Jennifer's narrative, doctors like her negotiate an identity hierarchy within the medical profession in the UK by moving into areas where there is '*opportunity for them to get work'* as there is '*less competition'* with those more privileged within the organisational hierarchy.

> *"Decisions to stay away from certain fields are conscious (…) colleagues and friends who are in gynaecology and obstetrics, it was challenging for them and if you were to look at the number of foreign-trained doctors, you will find out that a lot of them are based in psychiatric, mainly because the competition to get into this field is less than that of the surgeons and the gynaecologists for their counterparts. Not only that, you are sure that as a general practitioner, when you finish your training you will be accepted somewhere for you to work. Many of these people they strive and they finish up and they are worried about getting a consultant post or getting a job".* (Jennifer, doctor)

Jennifer contextualises the views of Quincy and Rose, in that choice of specialty is usually a *'conscious*' decision, a strategy by foreign-trained doctors to '*stay away*' from highly competitive specialties that consequently lead to no job or promotion in the future. This is then understood as creating a form of gravitation towards certain specialties where opportunities are available because there is '*less competition'*.

Some participants describe starting off in some specialties and getting consciously navigated towards another specialty that represented less competition for their identity categories, while others such as Rose veered to paediatrics, where she senses no threat from the white doctors. As Jennifer says, *"people tend to gravitate towards that specialty because... there is the opportunity for them to get work"*, meaning that opportunities provide a pull, but one that is not entirely choiceful since it is structured by organisational culture and the need for the individual to negotiate this culture (Acker, 2006).

The term *'gravitate'* takes away a sense of agency from the participants and implies a less than conscious or agentic process. However, in another part of her interview, Jennifer uses more agentic language, describing female Black doctors as taking '*decisions to stay away from certain fields [that] are conscious'* and based on reviewing the representation of '*foreign-trained doctors'* in certain specialisms as a way of determining their employment opportunities and making practical decisions on the basis of this assessment, rather than, for example, solutions based on their love, passion or talent for a specialist area.

The use of specialism as a coping mechanism to perceived sexist and/or racist discriminatory practices occurred for many of the doctors. Choice of specialty was a coping strategy which enabled these participants to thrive in less competitive specialties and allowed them flexibility and a work-family balance.

Conclusively, doctor participants described using their choice of specialty as a problem-based coping strategy to respond effectively to the threat and challenge (stressors) that their identity categories – both ascribed and acquired – posed in their employment and career progression in the medical profession in the UK (Goldacre, Davidson & Lambert, 2004). This led them to specialise in general practice (which was where most doctor participants (n=10) were located), psychiatrics (n=1) and paediatrics (n=1). These specialist areas were understood as either providing working practices that were compatible with their role as mothers, or that were less attractive to white or white male doctors who were privileged in a competitive organisational culture.

7.2.1.3 Conscious Positioning (Doctors): Regions

Conscious positioning in relation to geographic location was another strategy employed by the doctors to gain entry into the UK medical profession. These participants described moving to geographical locations in which their racialised and ethnic identities posed no threat and where

they were offered their first employment opportunities in the UK. Many doctor-participants mentioned Scotland or Northern England as favourable locations where Black and migrant identities were opportune for commencing their medical practice in the UK.

Anne had previously discussed deploying a strategy of moving from obstetrics and gynaecology to general practice to accommodate the needs of her family, thereby striking a work-family balance. However, in the extract below, Anne also describes employing a strategy of following the job and moving frequently to establish her professional identity in the UK.

> *"I have moved from place to place (…) having to relocate every time you get a new job, when I was in a trainee post… wherever the job was I had to go, and I had to move my son with me… it was really tough for me. But I had to do it, that was the only way that I could survive"* (Anne, doctor)

Moving from place to place seems to have been a frustrating experience for Anne, especially with her son. Anne narrates how challenging access to a trainee post was, since she had limited employment opportunities and had to go '*wherever the job was',* which for her was in multiple geographical locations. Moving to different locations created significant instability for her family, which made this training difficult '(*it was really tough for me')*. For Anne, the number of times she used the words '*I had to*' shows that this was not at all choiceful but linked to survival; this difficult process was experienced as her only option ('*that was the only way that I could survive'*). Thus, the solution to the stressor produces further stressors. In contrast, Jennifer describes the way geographical differences can be experienced as providing opportunities for immigrant doctors.

> *"it was the circumstance that opened up training in the remote area of Scotland, that has caused ethnic minority to migrate (…) going to some remote areas, and those areas open doors for foreign nationals, immigrants, and for people who under normal circumstances wouldn't have gone there"* (Jennifer, doctor)

For Jennifer, remote areas (presumably ones that are not as desirable in the competitive medical job market) '*open doors for foreign nationals, immigrants'*. A problem-based solution is thus to move to these areas where there are opportunities for migrants. However, as with Anne's story above, the solution to the stressors can in itself be a stressor, which is hinted at in Jennifer's extract since the opportunities in remote areas are taken up by people '*who under normal circumstances wouldn't have gone there'*. While at this point in the interview Jennifer does not describe why immigrants would not have gone there '*under normal circumstances,'* analysis in earlier chapters' points to some of this reasoning. These reasons include not being understood or understanding regional accents of patients, the climate, and being away from Nigerian communities or communities in which ethnic diversity is comparatively high. As Beverley said:

> "*there were more opportunities here in Scotland than in England (…) because of the cold and everything, you know, people don't really want to stay up here [Scotland]*" (Beverley, doctor)

It became clear that these regions are not desirable places to live for many of the doctor participants through their talk about moving back to London when they could, as Pippa and Mary describe below.

> *"Because London is very competitive, so there are more doctors than there are jobs … but if you go up North or maybe even Scotland it is very easy to get jobs for immigrants, if you go up to the North of England… So that was what I did, I applied in the North of England before moving back to London"* (Pippa, doctor)

Pippa reiterates Beverley's view of relocating to gain employment opportunities before moving back. Moving to a different geographic location was a difficult but strategic move, with her ascribed identity ('*very easy to get jobs for immigrants*') meaning she 'had to' make that move, away from the competitive nature of London, in order to get a foot in the door. Pippa indicates that immigrants have a prospect of success and survival in Scotland or the North of England, and afterwards, in her own case, are able to relocate back to London, her desired location.

> *"I had been in London while I was training, and I wanted to be in a place where I had more opportunities (…) Initially I was ready to go to the Outer Hebrides, that was where I got the job, my first job (…) relocated afterwards"* (Mary, doctor)

Mary reiterates the need for immigrants to be highly mobile ('*I was ready to go*') at the initial stage of the process of practising medicine in the UK as a foreign national as well as to survive the '*very competitive'* nature of places like London. The strategic move to the North, particularly Scotland (in Mary's case the Outer Hebrides) where there is easier access to jobs for immigrants, was a step towards achieving Mary's aim of being where she '*wanted to be in a place where I had more opportunities'*. Pippa and Mary identify this problem-focused individual solution based on their appraisal of a competitive job market underpinned by the devaluation of immigrant workers.

Beverley also went to Scotland, but unlike Mary and Pippa, chose to stay and enjoy working in a context where there were '*more opportunities*' which meant she could enjoy continuous employment, and career progression.

> *"(…) many of the people I trained with, once they finished their training they went down to England, I stayed on because there were more opportunities here in Scotland than in*

> *England (…) I have never lacked a job (…) the level I am I can choose a job wherever to be honest"* (Beverley, doctor)

Here is yet another conformation of the conscious positioning of immigrants in strategic geographic locations as a means to access more opportunities for employment and career progression; as Beverley says, '*I have never lacked a job*'.

Extant literature has shown that overseas-trained doctors move between geographic locations which provide them with access to medical practice (Mick, Lee & Wodchis, 2000; Han & Humphreys, 2005). This is used as a coping strategy by these doctors to consciously position themselves in the UK system. In this study, it was the Northern and/or regional parts of the UK, particularly Scotland and then the North East of England, that were seen as offering more opportunities, and so moving to these locations was a coping strategy adopted by the doctor-participants to gain initial access into the medical profession in the UK. The geographic location was thus identified by these participants as a key problem-focused strategy for initial access to training posts in situations where their acquired characteristic (immigrant status), as well as their racialised and gendered positionalities were understood as barriers to accessing the medical profession in the UK.

These participants also employed other coping strategies such as confrontation, which will be discussed in the section below.

7.2.1.4 Confrontation

This form of coping involved the direct tackling of challenges. Only three participants indicated the use of confrontation as a solution to their problem. One of these had a productive experience, while the other two participants were not successful. In chapter six, participants experienced a feeling of vulnerability and a fear of racially-motivated, unfair formal complaints being made against them, but few participants employed confrontation as a strategy to cope with that feeling of vulnerability. In contrast, Quincy fought an allegation against her and achieved a positive outcome, as she describes below.

> *"Despite being cleared of the allegations, that the allegations were still left in the public domain. And I had to start my second battle that it needs to be removed... and I fought against that... leaving the initial allegation in the public domain, whereas the clearing facts were not left in the public domains (…) eventually after two years the medical council then passed a resolution that once a doctor is cleared, all the allegations will be removed from the doctor's name and the register, and so that was incorporated in the general medical council regulations. So I felt that at least I achieved that for the minority workers"* (Quincy, doctor)

Quincy perceived the allegation against her as a battle which was not initiated or fought from the place of fear but rather initiated by anger. The desired outcome – the removal of the allegations against her from the public domain – was clear to her from the onset. Quincy's choice to adopt a problem-based solution, through confrontation on an institutional level, was because she felt she had been treated unfairly since the initial reporting was undertaken on *"a highly malicious level*". The outcome exceeded Quincy's expectation, as she felt she achieved social change for future doctors who faced unfair litigations. She felt personal empowerment ('*I achieved that for the*

minority workers') which also demonstrates that she understood the problem as racialised and discriminatory.

Another participant used the confrontation strategy but gave no indication of the success or failure of this strategy.

> *"…going back to work after my second child, I was going up for a promotion… I really felt at the time it was basically due to my race, I wasn't given the same opportunity (…) I did confront management, you know and I expressed my concerns about it, that I felt I was being discriminated against because it really seemed obvious. And apparently some of their people were being offered the same position, without even applying…"* (Eileen, nurse)

Eileen resorted to confrontation as a problem-based solution after perceiving racism at work on an institutional level. After making an assessment of the situation ('*not given the same opportunity*'), she adopted verbal confrontation as a strategy to address this problem racism at an institutional level. However, Eileen does not narrate the outcome of this confrontational strategy, if there were any benefits and at what cost.

Flora initiated confrontation as a coping strategy but then suppressed it and instead adopted an avoidance strategy:

> *"I am still wondering why he [lecturer] failed me, I could only come to the rightful conclusion that he was just victimising me … when I narrated it to my personal tutor (…) if you want, we could ask for a re-mark, we could query the grade, we could do all that, but I wouldn't advise you to … he knew the man was picking on me, even him his hands were tied, he couldn't do anything (…) Why because you are going to miss your graduation … this person is really out to victimise you. So, he said to me, I know it is painful, resubmit your work and get the minimum grade, and you will be able to graduate and leave with your set, which was what I did"* (Flora, nurse)

Flora's hesitation to confront and express anger directly was based on her evaluation of the situation with an authority figure as well as uncertainty surrounding whether the costs outweighed any benefit. The tutor acknowledges victimisation as a painful experience, which is validating for Flora. However, she felt helpless ('*even his hands were tied*'), as she sensed she lacked the resources to confront, and faced an uncertain outcome, coupled with the risk of not graduating with her classmates. Therefore, Flora reassessed the situation and succumbed to an avoidance strategy instead. This strategy is likely to be one shared by other participants, since the problem-based strategy of confrontation was used by few participants as a way to navigate the barriers faced at work.

7.2.1.5 Summary of Subordinate Theme One: Navigating Barriers to Good Employment

The above analysis has described how participants used the problem-based solutions of repositioning, conscious positioning and confrontation to address labour market challenges. The section below addresses their strategies for a different set of problems around domestic challenges. As well as the labour market and workplace, these participants also encountered domestic challenges at home, and described relying on family to share their domestic burden, a form of social support which provided an external resource used to cope with and mediate the negative effects of stress related to their migrant process of becoming, as well as the sexism and racism that they experienced at work and/or at home. This is the focus of the second subordinate theme discussed below.

7.2.2 Subordinate Theme Two: Seeking out Resources for Managing the Impossible

In chapter five, the second shift was experienced as a challenge by participants as they combined paid employment with their domestic and childcare responsibilities. This subordinate theme now presents the coping strategies devised by the participants as effective responses to the challenges they faced while doing the second shift. It focuses on the range of coping strategies devised by the different participants in navigating the challenges of combining paid employment with motherhood. While the nurses employed night shift work, agency work, childminders, and part time work as flexible work arrangements, the doctors employed private education and locum work. Analysis starts with examples of other people to whom the participants outsource their childcare responsibilities, and then discusses the flexible work arrangement employed by participants to achieve a healthy work-life balance while doing the second shift.

7.2.2.1 Outsourcing Childcare to Others

As discussed in chapter five, participants described their gendered national identity – that of Nigerian women – as salient in structuring their experience of their triple burden. Nigerian women were expected to perform traditional gender roles of a patriarchal society, meaning that in order to feel like good women, the participants needed to ensure their children and husbands' needs were met. The pressure of engaging in gainful employment and maintaining a home in the UK was challenging for the participants, who employed different coping strategies in which they relied on other people for help with childcare issues. These strategies included outsourcing

domestic and childcare responsibilities, taking on flexible work, relying on friends and family, and striving to achieve a work-family balance.

For most of the participants this meant doing the 'second shift', as evidenced by Sharon (nurse) in chapter five: "*even though you come back at 11pm you are still expected to get into the kitchen and do things, that's our culture".* Indeed, as argued in chapter five, the second shift could be conceptualised for the participants as arising from a triple burden: wifehood, motherhood and paid employment, all structured by their gender and ethnicity. Some participants also described relying on family to share the domestic burden, as Irene describes.

> *"the pressure on, on me as a woman… not having enough time … you don't have any help. You just have to get on with things and do it… in Nigeria where I didn't have to do those things, you have help. You have people who will do it for you at affordable rates… you can afford a chauffeur in Nigeria, you can afford a cook. You can afford a cleaner… It's been more difficult here (…) It was quite a challenge, but fortunately for me, I had extended family when I was studying"* (Irene, nurse)

As Irene illustrates above, in contrast to their experiences in Nigeria, the cost of outsourcing domestic work in the UK was prohibitive for participants. Thus, their main solution to the second shift/triple burden was employing the help of extended family. This solution was common across participants, including doctors and nurses.

Participants tended to outsource childcare. While Irene used family for this, Quincy sent her children to private school.

> *"Working as a doctor, married with children was quite, it is not easy. It is straddling a lot of jobs, so to say, but I had to rely on private education for the children because I could not give enough time in the home to bring them up (…) I must say because private*

> *education in the UK, still has a lot of the old values, both societal and ethical, it is still retained, and so that helped me a lot and the children have done very well."* (Quincy, doctor)

Quincy acknowledges the stress levels in her environment and employs a problem-based coping strategy based on physical resources to manage her competing work and family responsibilities, evident in her statement *'straddling a lot of jobs and relying on private education'*. Although private education is an under-researched form of coping strategy, her use of this choice is a reflection of her socio-economic resources and status, and the commodification of her children's education to alleviate her time demands with regards to her motherhood role in the family. This is an effective and successful strategy for Quincy, as it maps onto her values and means her children do well too. Private education is Quincy's response to the stressor of time-based conflicts and pressure in her environment, but is also connected to having older dependent children and the physical resources to cope with stress in her environment.

Therefore, in this context, professional status had some effect. While Quincy sent her children to private school, this contrasts with the nurses' solution of using childminders, as described in the subsequent extracts.

> *"as a professional as well, and a wife and a homemaker (…) So sometimes you work five days in a row, or four days in a row, which is really difficult for us, for me as a mother and a wife… you just have to carry on the much you can with God's grace you. On a typical day I wake up in the morning like about five o'clock, and prepare myself and my children and take them to the childminder before going to work" (Cathryn, nurse)*

> *"It wasn't easy because I had to leave her and her sister with the child minder… because I do a 12 hour shift from 6.30 to 7.30, then I get home at nine pm and I have to go pick them from the childminder and this is three or four times a week so it was really tough…" (Helen, nurse)*

Cathryn and Helen both use words such as '*difficult*' and '*tough*' to describe the challenging situation in their environment and their choice of childminding as a coping strategy. Cathryn contextualises her situation as the gendering of domestic tasks and chooses to combine various options such as outsourcing the childcare and working as hard as possible for the unpaid domestic tasks, saying *'you have to carry on the much you can*'. Cathryn also describes another, more emotional coping strategy of spiritual support, saying '*with God's grace*' (see section 7.2.3.3 for further discussion of spiritual coping practices). In the section below, participants employ different flexible work arrangements as strategies to cope with their second shift.

7.2.2.2 Flexible Work Time

Flexible working arrangements gave participants control over their time use, enabling the possibility of maintaining paid employment with family duties, whether participants were part of a dual-earner or single-parent family structure, while also managing the triple burden that their role conflicts brings. Indeed, many of the participants' narratives were concerned with seeking the ability to exercise choice and agency, which doctors did through locum jobs and nurses through agency work. Below are extracts from the participants that illustrate how flexible work arrangements enabled the participants to cope with the second shift.

> *"I like the flexibility that I work for myself, because of the way they do the shifts (…) Especially if it is a one-parent home, like a single parent, it is not easy to get childminder round the clock, so it is good if you are able to work for yourself and do your agency work, whereby you work when it is ok for you in your circumstances"* (Ursula, nurse)

> *"I went into agency work because my son was still quite young at the time (…) Being agency, I was my boss, I could choose when I wanted to work … I can actually work with him, when he is on mid-term and holidays, and do the extra shifts if I have to, just to balance my finances"* (Tracy, nurse)

In the extracts above, both Ursula and Tracy narrate the benefits of working as agency nurses as this allows them to work flexible hours. Ursula describes her choice of temporary agency work as a form of coping strategy based on her single parenthood structure, which produced a need for her to work flexibly around her parenting role, with the implication that she is mostly doing this alone. For Ursula, flexibility and control over her time use are key factors that aided her choice of agency work. Again, time is an important factor in this choice of coping with her *'circumstances'*; by stating that she can't get a childminder round the clock, Ursula indicates the need for time with her child.

For Tracy, being a working mum of a dependent child ('*my son was very young at the time*') meant time for her son was a valuable resource in undertaking the seemingly impossible – doing motherhood with a career – hence employing agency work as a coping strategy. Again, there is no indication of a partner or a husband in the picture. Tracy describes using agency work to prioritise her childcare responsibilities, while also being able to meet her financial needs, taking time off, for example, during half term and working more shifts at other times (*'do the extra shifts if I have to, just to balance my finances'*). Similarly, control and flexibility are also key factors for Tracy, as well as a sense of autonomy and choice, reflected in her statement, '*I was my boss, I could choose when I wanted to work*'.

Below, Anne, describes a similar strategy and rationale for doing locum GP work.

> *"I am a locum GP; I work anywhere … so it is working nicely for me now (…) That is what I decided to do because of the family, I wanted to spend more time with the family, because I wanted to do some home runs…"* (Anne, doctor)

Anne chose a flexible arrangement in the medical profession by working as a locum GP. She enjoyed the flexible time and location that this work afforded her as alternative way of organising work around her family, thus gaining control over her time use and perhaps even some pleasure in her family duties, which are hinted at in her phrases '*wanted to do some home runs'*, '*I wanted to spend more time with the family',* and '*it is working nicely for me now'*. Located in a dual-earner family structure (see chapter five where Anne talked about coming back from work at the same time as her husband), this GP's choice and ability to work flexibly and with agency and control over her work times means that locum work is a problem-based solution that also meets her emotional needs.

However, choosing to move to flexible working hours in order to meet their (gendered) childcare responsibilities often created other stressors in the participants lives. Such stressors included those related to reduced career progression, so that prioritising childcare came at a cost to participants' self-development, or, as in Irene's extract below, at a cost to income.

Below, Irene describes how working part-time was the means she devised to work around her family, this approach cost her a reduction in income.

> "*They [her children] are grown up now. They can go to school by themselves and all that, but there's still the pressure of hmmm, of you not having enough time, because you find that there are stages in their lives; they are doing their A levels, going through*

> *university (…) go higher in the career, the job is demanding more of your time… I find that I have had to reduce my working hours, take a cut in pay, just to make out time for this. You just have to devise ways of, you know meeting any challenges that you find*" (Irene, nurse)

Even when parenting children who are relatively independent (who '*can go to school by themselves'* or are adults at university or with their own careers) Irene describes the need to organise her work around meeting the needs of her children. She describes this as a challenge, for example, through her use of the word '*pressures'*, pressures which increase as she progresses in her career ('*the job is demanding more of your time*'). Faced with the need to both care for her children whose need for her does not diminish over time and her demanding job which increases in its demands over time, she makes the choice of part-time work. However, this means a loss to herself since she has to '*take a pay cut*'. Irene's assessment of the challenges she faces meant prioritising her tasks; and to meet her children's needs (and thus, perhaps her identity as a good mother, see chapter five, section 5.2.1), Irene allocated less time to paid employment, which was the method she devised for meeting this challenge.

Having time for the family, particularly children, seemed incredibly important for these participants regardless of those children's level of dependence or independence. And a range of problem-based strategies were employed. For example, Tracy, with a dependent child, used agency work as a coping strategy, while Irene found that part-time work was more beneficial for her. On the other hand, Eileen navigated the challenges of balancing paid employment with motherhood by working a night shift pattern, although this also came at a cost.

> *"it is difficult being a mom, isn't it (…) if your husband is posted, you wouldn't leave a little child (…) a big responsibility is on me for the children, my husband is really*

> *supportive… I have to work shifts, so he has to be at home at night and look after them but still the onus is on you and so my priorities are mainly now raising the children, so it affects my progression in my career … prior to having children, I was able to push a lot more, and move a bit further on. Once I had kids my priorities did change (…) getting flexible working hours, those things have really helped me, to be able to do my job and help me look after my children"* (Eileen, nurse)

Eileen noted that flexible working arrangements in combination with support from her husband reduced her work-family conflict; however, this choice cost her in terms of career progression. Although part of a dual-earner family structure with dependent children, Eileen describes the bulk of childcare and domestic responsibilities as resting on her ('*a big responsibility is on me*') and that to both meet this responsibility and work she finds a solution in working night shifts. This illustrates how a flexible working arrangement worked as a coping strategy for Eileen, and she describes it as an option that '*really helped me*' in terms of managing having both a career and children. Yet, this is at a cost ('*it affects my progression in my career'*). Work-life balance is rooted in one's identity, and in Eileen's case, as a mother, she has gendered roles in the family that define her experience, which leads to compromise and a loss of an imagined self who might have moved '*a bit further on*'.

7.2.2.3 Summary of Subordinate Theme Two: Seeking Resources for Managing the Impossible

Having access to flexible working arrangements and consequently having time for the family, particularly the children, was a useful resource. Other positive aspects of flexible working were tied to issues of choice, a sense of agency, and the ability to enjoy one's mothering and childcare

responsibilities. Although flexible working was for the most part discussed positively, it and other problem based strategies that the participants employed described above, often produced new stressors. In this sense these strategies were only partially successful in moving the participants out of difficult situations. But, participants did not only employ problem-based coping strategies, they also relied on strategies that were emotion-based, and these are the focus of the next section.

7.2.3 Subordinate Theme Three: Emotional Strength

In this subordinate theme, I focus on the way some participants described the importance of family and friends as a mechanism for providing emotion-based coping strategies, as well as the importance of simply seeing other people like them. It is not surprising then that participants in this study described social support as an important emotion-based solution to the stresses they experienced.

7.2.3.1 Comfort in not Being Alone

In chapter five, some participants narrated their awareness of being visible minorities in their places of work. Seeing other African people provided a sense of comfort either because of a sense of shared experience, as Cathryn describes below, *'90 percent of us went through challenges or hardship in life*', or as in Linda's extract that follows, simply because it meant they

were are not alone. Such talk led to the subordinate theme 'comfort in not being alone', exemplar extracts are given below.

> *"You'd always like to see people from the same continent as you, you know, there will be similarities in the way we see things in life (…) 90 percent of us went through challenges or hardship in life. That [the challenges] alone has shaped every single one of us, and we understand each other more than our counterpart … so when I have somebody from my own ethnic group, a Black person, an Asian person, a Pakistani, they will prefer to come closer to you than to the white person"* (Cathryn, nurse)

> *"in the UK you have what they call the ethnic minorities, and they are lumped together, and in a funny and unique way there are similarities, because if you brought out a Black person, and an Asian person and a Chinese person, for some strange reason, if they are up against a white person, they will feel that brotherhood as opposed to a pure Caucasian. Suddenly an Asian becomes your brother or an Indian becomes your sister"* (Jennifer, doctor)

> *"being a Black person in the UK … I felt like I was not accepted (…) why I went into nursing was that there were a couple of other Black people in there that made me feel a bit more comfortable…"* (Linda, nurse)

Linda, Jennifer and Cathryn's extracts can be contextualised within the struggles of African immigrants in a racist culture, as described in chapters five and six. These participants describe a sense of camaraderie and understanding of each other that is, as Linda says, *'comfortable'* and in Jennifer's words, a sense of brotherhood and sisterhood. If the multiple dis-preferred positions create a sense of misrecognition, of not having a value in society, then being with other Black or even just non-white people ('*a Black person, an Asian person, a Pakistani')* provided recognition and a sense of common humanity. As such, this is an emotional strategy, one that allows the participant a sense of comfort and belonging.

Other participants talked about family providing specific support. Family was often seen as essential, as Mary, a doctor participant, said: "*family... made it possible for me, with living in a foreign countr*y". Vicky, a nurse participant, stated that: "*family was really an essential part of my life*", and recounted that the happiest day of her life was when her sister made it to the UK.

Family provides emotional support, for example, for Beverley, who as a Black female doctor finds it *'lonely at the top'*:

> *"I have been able to get to where I am because of my family. I believe family is very important, and you know, no matter how high you go, if you don't have your family with you, when you get, it is lonely at the top (…) you can look around and see all the stars [celebrities], and so, why do they move from drug to drug, from person to person … and before you know it that person has died from drugs overdose (…) I enjoy my husband's love and support (…) There were days I didn't even want to wake up, so maybe looking back, maybe I was depressed you know, when you say somebody is depressed, that probably was depression. But thankfully, family, you know, I remember my sister crying with me"* (Beverley, doctor)

Social support in Beverley's case is her family, her husband and children, although she recognises that that is not the case for everyone. Beverley refers to the kind of social support she received from her family – a listening ear, a shoulder to cry and lean on, irrespective of the time of day – and emphasises the importance of social support to maintain one's sanity '*at the top*' and avoid reliance on drugs. The celebrities she mentions in the extract above seem to lack vital support; she perceives that they search for this support '*from drug to drug, from person to person*'. In comparing her experience with theirs, she refers to what they have in common, occupying a position '*at the top*' with lots of responsibilities and accountability to the people who look up to them. In her second interview, Beverley pointed out that her husband delayed his career and stayed back at home with the children while she carried on work as the primary

earning migrant. The advancement of her career was at a cost to her husband's career, which explains her statement '*I enjoy my husband's love and support*'. Beverley also had the support of her sister and referred to a time when she was going through unemployment in the early post-migration stage and had social family support – a sister to '*cry with her'* – for which she was grateful. Beverley assessed that the social support system she has in place helped her cope with her gendered domestic responsibilities, helped her cope with unemployment-related depression, and aided her career progression.

Like Beverley, Karen also had the support of her husband.

> *"I have a very good and supportive husband, without which I don't think I would be where I am today, he sacrificed so much in order for me to progress in my career (…) the things a woman should do, which I have not been able to do, he's having to do them… you are just all over the place, and being a mother and a wife, you can't just do that"*
> (Karen, doctor)

For Karen, who unusually had a husband who took on domestic responsibilities, this support allowed her not only to '*to progress in my career*' thanks to the additional time afforded to her (as in the section on outsourcing discussed above), but also provided physical and emotional support for their children; her husband undertook '*the things a woman should do',* which she has '*not been able to do*', fulfilling her role while she is '*just all over the place*' because of work responsibilities. Like Beverley, her husband '*sacrificed so much*' to bear the cost of her career progression, but Karen, unlike Beverley, was a dependant migrant. She coped with the challenges of mothering and paid employment because of the cover her '*supportive husband*' provided.

Emotional support from close family were thus important aspects that enabled the participants to succeed at work. However, as migrants, participants had by definition often left family in their ancestral country, Nigeria. Thus, just as sources of labour/material support were reduced for them (as discussed in the chapter 5), so too were such sources of emotional support. Overall, however, both doctor and nurse participants described relying on some social support, which provided an external coping resource that they used to mediate the negative effects of stress related to their migrant process of becoming, as well as the sexism and racism they experienced at work and/or at home.

Apart from relying on external resources of emotional support, many of the participants also relied on internal sources. In particular, strength through faith in God stood out. This will be discussed in the section below.

7.2.3.3 Strength Through Faith

Many of the participants, both doctors and nurses, described their faith in God as a considerable source of emotional support and a central coping strategy for responding to challenges both at work and at home. Jennifer's extract below reiterates the view of faith in God as a central coping strategy not just for the Nigerians in this study, but as a central coping strategy for Black Africans more generally.

> *"I am a Christian, and I really depend on God, and because I depend on God and my faith is very strong (...) It's interesting that you didn't write religion up there … that [religion] is a driving force for black and ethnic people, specifically Black Africans because amongst the Black people it is something that is up there"* (Jennifer, doctor)

The psychological salience of faith has an impact on Jennifer's positivity, and she acknowledges religiosity and spirituality as a collective coping strategy, as they are so common amongst Black people. Jennifer's comment on the fact that religion was not on the list of words used in the card sort activity indicates the centrality of faith and religion ('*driving force*') to the Nigerian identity as well as for other Black and ethnic people. This extract was purposefully chosen to highlight this centrality of faith and a religious identity. Mary' extract below, shows the further function that being a Christian serves in relation to coping with discrimination when moving to in the UK.

> *"Being a Christian sometimes makes you, kind of think about a higher power being in charge of things that happen, so that sometimes, and occasions where you might feel that there is an obvious reaction to you on the basis of either my gender or my race or the fact that I am a migrant. Being a Christian, it kind of helps you modify your reaction, or your understanding of it, and your ability to cope with it…"* (Mary, doctor)

Mary describes the mediating effect that believing in a high power has on her responses to racism and sexism, and any other form of discrimination. Mary connects her Christian faith and belief to a transcendent being who has ultimate authority *('higher power being in charge of things that happen')* and describes how this helps to provide the meaning that defines her response in discriminatory circumstances, resulting in an '*ability to cope with it'*.

For other participants, belief in God was experienced as providing direct guidance on how to manage the multiple roles that women like Cathryn had to manage:

> *"in terms of juggling life, your family, work, you know home life, being a mother, being a wife as you yourself are in the same position. It hasn't been easy but we thank God that He is always there to guide us on how to be able to multitask, erm, and carry out our duties as you know, as mothers. And as a professional as well, and a wife and a homemaker as well."* (Cathryn, nurse)

Cathryn extends her faith to coping with the daily difficulties encountered in her home and work environments. She highlights the way her faith is practiced alongside problem-based solutions, thus *'multitasking'* in relation to institutional and cultural racism and sexism. Cathryn repeatedly refers to her membership to a collective identity, using terms like 'we' and 'us' *('we thank God', 'to guide us', 'carry out our duties... as mothers'*), which also lay emphasis on faith being a collective coping strategy by this group. In so doing, Cathryn ties faith to guidance on the practical problems experienced as a result of her roles as a mother, wife and homemaker, and to having a wider sense of community and connection with other women like her. That such other women are also Black and/or Nigerian is an important aspect of this connection. For example, at another point in the interview Cathryn linked being Nigerian with being Christian, saying: *"we Nigerians, Christians, we believe in God that something is going to be possible regardless of all obstacles".* Religious beliefs, as a form of emotion-based coping strategy, thus intersect with racialised and gendered identities.

In the extracts below, Irene and Cathryn can be seen to combine a number of emotion-based solutions.

> *"It was initially difficult for me, up to the extent that it was affecting my health, I wasn't really sleeping, I cried all night (…) but now I can, I have someone to talk to, I have*

> *friends to confide in (…) support from people makes it easier to deal with the challenges… we believe that there is nothing impossible with God. No matter the challenges that we are going through that there is always hope that it is going to come out positive"* (Cathryn, nurse)

> *"You have a lot of challenges coming from everywhere … to get to where I am … pushing yourself forward, developing yourself, improving yourself. You know just going with your 'can-do' attitude, doggedly going with everything... there's also the element of your faith, your belief, your spirituality; it's all these things, you know, that help to move you forward"* (Irene, nurse)

Cathryn employs social support and spiritual-based resources to cope with the difficulties and challenges she encounters, while and Irene combines spirituality and a *'can-do'* attitude. God provides hope ('*there is nothing impossible with God*'). Although life in the UK was difficult at first for Cathryn, in this extract she describes being able to find resources to overcome these challenges through her religion and religious support group ('*we believe*'), which provided both external social support ('*friends to confide in [and] support from people'*) and a more internally experienced emotional support, since her faith gives her a sense of hope that cannot be extinguished ('*with God [...] there is always hope'*).

Irene also combines strategies in her extract above. Describing her situation as difficult in all contexts ('*challenges coming from everywhere'),* she employs internal resources located in her psychological attitude, a *'can-do attitude, doggedly going with everything'*. However, this attitude is not enough, since there is '*also the element of your faith, your belief, your spirituality'.* It is this combination of attitude and faith that provides a successful emotion-based coping strategy for Irene that was instrumental in her progress '*to move you forward*'.

As well as providing a sense of inner strength, participants described the doctrine of Christianity as enabling them to change their perception and thus respond to challenges that might otherwise have produced negative emotions in them. As Eileen, a nurse, said: "*being a Christian, I try to see everyone the way God sees them, that's what I try to do, so my faith also affects my perception"*. Jennifer also echoed this view of drawing positivity from her Christian faith in her statement, "*because I am a Christian, some of my ideas, and experiences, and even the way I see things might be a bit different from what is the norm. So at the end of the day I am quite a positive person*".

In the section below, I consider another factor that fed into to the participants 'can do' resilience. These extracts focus on the mental processes which some participants perceive to be connected to them being Nigerians and Blacks and which enable these participants to cope with discrimination in a high-pressure environment.

7.2.3.4 Building your own Resilience as a Nigerian

Participants drew on an identity of being resilient. This identity worked as an internal resource that helped them cope with living and working in such a high-pressure society, and which they attributed to developing while living in their ancestral country Nigeria. Some participants tied resilience, which had developed over the years, to being Nigerian, while others connected it with being Christian.

In the interviews, Cathryn, Sharon, and Beverley linked their resilience to being Nigerian, while Cathryn and Beverley also associated it with a resource gained from their Christian faith. The repetition of this issue in the extracts below demonstrates its shared understanding across the participants.

> *"As a Nigerian (…) we all know we can make something out of nothing… the background already, you know, prepares us for whatever situations we find ourselves… to achieve what we want to achieve… we Nigerians, Christians, we believe in God that something is going to be possible regardless of all obstacles, definitely, you will achieve your aim if you keep pushing…" (Cathryn, nurse)*

> *"We Nigerians, we are very, very strong, hustlers, so we kind of survive in any condition we find ourselves in…" (Sharon, nurse)*

> *"It is something that is learnt from one's background (…) that came with my Christian upbringing... but it can also be an acquired thing… so a lot of people acquire the resilience when they come over here and find out that things are tough, you just have to get on with it" (Beverley, doctor)*

> *"from being a child you are always told the person that came first does he have two heads… so all those things help build resilience" (Rose, doctor)*

> *"I think it comes from upbringing, it comes from, hmm, other people mirroring to you that when things happen you react in this way (…) as you grow, you build up that, hmm, ways of responding to things, you build up that resilience…" (Mary, doctor)*

Participants' perception of resilience was developed over time from childhood, while environmental factors in their upbringing also played a role. Cathryn, Mary and Beverley mentioned the function of one's background and upbringing in shaping their responses to

stressful situations, thus developing resilience in the process. Cathryn also believes that your background prepares you in advance, Beverley's extract acknowledges this while also stating that resilience can be acquired. Adding to this, Mary and Rose believe that past experiences build up in people, resulting in an accumulation which develops into resilience over time.

The resilience developed and internalised in these participants over the years served as an internal resource that helped them adapt well to challenges at work and at home, was based on successful handling of past challenges, and helps them maintain a hopeful outlook to handle future challenges. In describing this interpretation, the participants used such phrases such as, '*keep pushing*', '*you just have to get on with it*', '*not to give up and keep going*', '*we survive in any condition we find ourselves*' to depict resilience. Rose also described a popular saying repeatedly said to Nigerian children in the face of defeat or failure while growing up, and also familiar to me as a Nigerian, that '*the person that came first does he have two heads*', simply meaning the winner is mere human like you and not a supernatural being with supernatural powers. Therefore, if they can do it, so can you, so keep going and don't give up.

The extracts above show the interconnectedness between Christian faith, the environmental factors of upbringing and background, and achieving resilience as Nigerian people. While for most participants, resilience was developed from childhood and helped them adapt positively to negative situations, interestingly they also drew positive energy and had a positive outlook on adversity as a result of their Christian belief. Resilience which had been developed over the years

was an internal resource for the participants to draw from in coping with the discrimination (sexism, racism) and challenges they encountered in the 'process of becoming'.

7.2.3.5 Summary of Subordinate Theme Three: Emotional Strength

Two main factors sustained participants through their challenges and negative encounters at work and at home: drawing emotional strength from loved ones, and from having a relationship with God, thereby drawing on spiritually-based emotion as proposed by Shorter-Gooden (2004). The mental processing of their encounters reveals a forward-looking, positive outlook ('*keep going*', '*keep pushing*', '*get on with it*') on negative encounters, which they developed from environmental and Christian backgrounds. They acknowledged challenges and adversity, yet maintained a positivity that enabled them to find ways of responding.

7.3 Discussion and Conclusion

In the introduction to this chapter, I highlighted the fact that coping strategies for Black women might be emotion-based or problem-based, and went on to show that, within this dichotomy, such strategies could be located at the individual, institutional or cultural level, depending on how those women appraised the stressors and resources they had to hand. This chapter above the other analysis ones, also showed clearer distinctions between the nurse and doctor experiences. For example, I showed how the doctor participants chose the problem-based coping strategies at the individual level of choosing their medical specialism or place of work as a response to discrimination that they experienced at an institutional and/or cultural level. I note that this

strategy was successful in allowing the doctors to gain good employment, but what was absent in most of the participants' sense making was an understanding that they might challenge the discrimination they encountered. Not challenging their experiences of discrimination thus denied them the possibility of emotional solutions, such as being angry or following the career of their passions. Instead, this individualised strategy of not competing for roles valued by white or white male doctors meant that the doctors worked in specialisms or locations that were less desirable.

Dominant theories of stress and coping posit that people's ability to cope is dependent on their assessment of individual situations in their environment while also being dependent on the resources available at their disposal (Endler & Parker, 1990; Carver, Scheier & Weintraub, 1989). People either employ a problem-focused strategy in which stress is reduced by directly targeting the situation/problem, or they employ an emotion-based strategy by responding in ways aimed to reduce the intensity of negative emotion caused by the stress (Carver et al., 1989).

In Lazarus and Folkman's (1985) model of problem-based coping, they argue that individuals can adopt solution-oriented behavioural strategies aimed at changing the stressor rather than changing their emotional response to it. As can be seen in the analysis above, this approach to negotiating the stressors participants described in chapters five and six was dominant, and was oriented around finding ways to navigate through what participants experienced as a highly racist, sexist, and anti-immigrant culture. These ideas arising from psychological research on coping will structure this discussion of participants' narratives, allowing an analysis of their individual coping styles in the context of their environment.

In chapter three, I argued that Lazarus and Folkman's conceptualisation of stress and coping as a process can offer a lens for examining the relationship of a person with their environment as well as how the person might respond to stressful situations in their environment (Lazarus & Folkman, 1985). This can be seen in the ways in which participants employed different coping strategies in their different work and home environments, assessing when to use emotion-based and problem-based coping strategies. Lazarus (1993) argued that individuals appraise and manage stress through cognitive and behavioural efforts. However, Lazarus' concept of stress and coping recognises the contextual influences and variance in coping over time and across different stressful encounters. It therefore acknowledges change over time and so is particularly useful for this study, as the migrant experience is characterised by both change and stressful encounters. Lazarus (1993) argued that, when assessing the situation, the individual engages in a primary appraisal to ascertain whether it is harmful, beneficial, threatening or challenging; and to assess what available external or internal resources they have to respond to the stressful event. These appraisals produce a move towards either problem-based or emotion-based coping strategies.

Past research on coping with stressors therefore suggests that research on Black women's experience and responses to stressors should focus on addressing the following questions: what these women consider stressful, the ways in which they appraise the situation (as harmful, beneficial, threatening or challenging), their assessment of whether their available coping resources are external or internal, the nature of discrimination (such as sexist, racist or intersections of gender and race), and the level of discrimination (individual, institutional, or

cultural). The analysis presented in this chapter suggests that the participants in this study made such assessments, from which they employed a range of coping strategies depending on how they understood the nature of discrimination (sexism, racism, or gendered racism) and their analysis of the level of that discrimination (individual, institutional, or cultural).

Most of the nurse-participants narrated the ways in which they appraised their employment situations, particularly Gail who used the phrase '*toxic trio*' to indicate identities that were potentially harmful for her work situation, and assessed that getting a nursing degree from a UK university would avert the situation of '*putting herself through hell*'. Gail assesses her situation of unemployment, and employs a problem-based solution to counter the threat she senses her nursing diploma to be, coupled with her qualification being foreign. Gail also felt the racial and gendered discrimination against her was at an institutional level. Gail appraised her access to a UK nursing degree, an individual solution, as an external resource available to her to counter these threats to her ascribed and acquired characteristics, thus, enhancing her acquired status. The doctor-participants also assessed their challenges in the labour market and responded by consciously positioning themselves in relation to specialisms they 'chose' and geographic locations in which they practised. Again, this is an individual solution but enabled in part by institutional racism, as participants could not specialise in their desired specialisms or practise in their desired geographic location, mixed with the cultural factor of London being more popular for them. Overall, the outcome of their assessment of their experiences in the labour market led them to respond by employing problem-based coping strategies such as acquiring and maintaining a new professional status.

Acquired status characteristics may allow people with low ascribed status characteristics to increase their overall status (Hutnik, 1991; Aboud, 1988). In the narratives above, there is a perception of status diminution, as well as a decreased professional disregard and a relative ranking of groups in terms of influence and privilege (Neeley, 2013). Participants sought to alter the problem – diminished employability – and to enhance their status through effortful achievements (Thomas-Hunt & Phillips, 2011). Their ascribed status as immigrants and Blacks meant that they could not access the UK labour market and practise in their desired professions. However, the nurse-participants took opportunities of the demand for migrants in nursing – as Irene stated '*there was still need for migrants in the field of health care'* – as a means to an end in terms of enhancing their statuses. In the current study, nurse participants navigate the barriers to good employment brought about by their low ascribed status characteristics and reposition themselves through acquiring a new professional identity. In the next paragraph, looks at the coping strategies employed by the doctors.

Gender plays a constitutive element in the choice of specialties of medical students, being a mediating role in the concentration of men and women into specialties in the medical profession (Crompton & Lyonette, 2011). Acker (1990, 2006) emphasised the embeddedness of gender in the structuring processes of organisations, and in particular of hierarchical organisations. The gendered domestic responsibilities of women have also contributed to the clustering of women in specialties such as paediatrics, general practice, and psychiatry (Nora et al., 1996). The findings of this study provide further empirical support for this previous research. Quincy and Anne deployed a problem-based coping strategy as a response to the challenges they perceived of working in obstetrics and gynaecology. They undertook a change of specialism to accommodate

their gendered domestic responsibilities and achieve a work-life balance. This is also related to and can help explain the underrepresentation of women in specialties such as surgery (Nora et al., 1996; Jagsi, Griffith, DeCastro & Ubel, 2014). Research has also shown that non-white, ethnic minority overseas-trained medical professionals are concentrated in the less popular specialties in the UK (Goldacre, Davidson & Lambert, 2004), as in the case of Rose, who consciously positioned herself in paediatrics, an undesirable and less competitive specialism.

Acker (2006) argued that work organised around practices such as long hours create inequality regimes, since they leave women feeling marginalised, uncomfortable, and as outsiders who do not belong. Women therefore have to employ coping strategies to deal with these inequality regimes. In the above extracts, Pippa and Anne describe such coping strategies. Appraising the situation, Anne found the work culture '*stressful*', while Pippa explained it was '*difficult*'. Both consider the work culture bad for their families, but Pippa suggests that this had a knock-on effect and is also bad for the individual herself ('*not really good for one'*). Their solution to this gendered problem is an avoidance strategy and moving towards a specialty – general practice – that had a work culture compatible with their family responsibilities.

Extant literature has shown that overseas-trained doctors move between geographic locations that provide them with access to medical practice (Mick, Lee & Wodchis, 2000; Han & Humphreys, 2005). Some of the participants, including Pippa, Mary, Anne, Beverley, and Jennifer, noted that movement to certain locations was a problem-based coping strategy they employed to overcome the challenge of accessing and progressing in the medical profession. It is

noteworthy that Anne employed both a change geographic location and a change of specialism to tackle the challenges she experienced in the workplace. However, constant relocation produced its own stressors for Anne.

Folkman and Lazarus (1988) posit that confrontation is a coping strategy that is initiated and motivated by anger, meaning individuals confront stressful situations in their environment and respond to the anger they feel at the stressor. Another factor considered in responding to stressful situations through confrontation is the expected interpersonal cost, for example being seen as a trouble-maker, versus the expected outcome, such as either reduced prejudice or increased antagonism (Kaiser & Miller, 2004). Hyers (2007) identified confrontation as an uncommon problem-based solution in cases of racism, since assessment of the expected outcome, costs and benefits determines the choice of strategy. Flora's case supports the view of Hyers (2007), as she took the avoidance strategy instead of confronting what she sensed was a racist encounter with her lecturer, since the cost of not graduating with her friends far outweighed the benefit asking for her paper to be re-marked. On the other hand, Quincy chose to confront the medical council after the bad experience of a litigation against her. The benefit for her was that, "*once a doctor is cleared, all the allegations will be removed from the doctor's name and the register"* and in terms of a personal, emotional benefit, *"I achieved that for the minority workers"*. It is notable that Quincy is the only participant that both describes successfully using the confrontation strategy – despite so many of the participants being angry over perceived discrimination. This suggests that the expected interpersonal costs of calling out discrimination is considered too high.

Outsourcing as a coping strategy for multiple roles and responsibilities was clearly useful for the participants, as it enabled them to manage paid and unpaid role conflicts (De Ruijter, Treas & Cohen, 2005; De Ruijter & Van der Lippe, 2007). The choice of coping strategies employed was reflective of participants' physical resources and based on their socio-economic status. Also common to these women was the factor of time availability, since the participants were engaged in full-time employment, and tended to be mothering dependent and independent children in the context of culturally expected traditional gender norms. However, outsourcing reduced participants' time with their children. Participants also chose the strategy of reducing their paid work, shifting to flexible or part time work. As Irene (nurse) stated, '*I have had to reduce my working hours, take a cut in pay, just to make out time*'. This flexible work arrangement was another coping strategy employed by some participants.

Participants also described emotion-based coping strategies to the racism and sexism they experienced as Black Nigerian women in the home and at work. Here, professional status did not impact on their solutions, since both doctors and nurses described drawing on social and spiritual support. Family and members of their wider community, who were often linked to their Church, provided emotional support, such as providing an opportunity to be listened to. However, emotional support was also experienced from a sense of not being alone, but instead part of a community of Black (and/or non-white) women who, through not being white within a white-privileged world, shared a common experience.

Religion also provided a central emotion-based coping strategy. Religion was deeply interconnected with participants' sense of being Nigerian and provided a range of ways for

coping with stress and feeling resilient in the face of significant challenges. These ways included a sense of there being a higher power, and thus an external authority to which participants could turn, as well as an inner strength produced by the hope instigated by their faith. In addition, participants' religious doctrine provided them with alternative ways to respond to those who discriminated against them, so that rather than become bitter or hurt by discriminatory practices, they could practice a Christian forgiveness that facilitated a sense of resilience. Being Nigerian also offered participants an identity associated with resilience, giving them an emotionally strong standpoint from which they could meet their challenges. Although in earlier chapters being a Nigerian woman was identified as producing particular stressors in participants' lives, such as producing an obligation to do the 'second shift' (see chapter six) or to abide by their husbands' decision to move to the UK (see chapter five), here, the identity of being a Nigerian woman was shown to also be a source of strength and a coping strategy for the stressors it produced.

In sum, past research on coping with stressors suggests that Black women might respond to stressors through problem-based, emotion based and/or culturally based solutions. Participants in this study described experiencing a range of discriminatory practices directed at them because they held multiple dis-preferred identities as Black, African, migrant women. They interpreted these discriminatory practices as both harmful and challenging, and sought to address them in a range of ways.

Problem-based solutions were employed mostly at the individual level, such as seeking employment that was more valued (for example as a nurse) or where there was less competition with white people (such as in regional work as a doctor). Occasionally, participants attempted

institutional level problem-based solutions (see section 7.2.1.4), but few chose this option, perhaps because in line with Flora's thinking, they appraised an imbalance of status that made this too risky a solution.

Emotion-based solutions were also employed. These had a more cultural and community element, since they were linked to collective identities such as being Black women, members of a Church, or as Nigerians, and often involved the intersections of these identities. Here, while the level of discrimination could be appraised as individual, institutional, or cultural, the solutions were around drawing emotional support from others, from a higher power who provided guidance and strength, or from identification as part of a group who could be relied on to overcome challenges. Thus, while these challenges were produced because of participants' location as Nigerian Black women at individual level, it was this positionality that was also experienced as providing cultural and emotional support. Therefore, while this chapter supports Lazarus and Folkman's framework for conceptualising responses to stressors, it also points to the importance of locating these responses within wider cultural context, which for Black African-identified women also includes religion and identities that intersect along a racialised, ethnic, national, and gendered axis. The next chapter will look at the research findings and key contributions to research.

CHAPTER 8 CONCLUSION

In this final chapter, I return to my research questions, answering them through a discussion of the findings of the analysis chapters five, six and seven (section 8.2). I then relate these findings to past literature, highlighting the contribution of the thesis in three ways. Firstly, by explicitly bringing together the literatures on identity and becoming, intersectionality, and inequality regimes which, while sharing some key concerns, are relatively disparate due to their location in the different academic disciplines of cultural and organisational studies. Secondly, by considering the ways in which taking an intersectional feminist approach – harnessed to the method of IPA – develops migration research in significant ways by making visible women's participation and experiences of international migration. And thirdly, by applying an African-centred cultural perspective to traditional psychological models of stress in order to better understand the strategies that migrant women may use when negotiating the multiple intersections of discrimination that they experience, particularly within an organisational setting. These three areas of contribution are addressed in section 8.3, after which I discuss the limitations of the study (section 8.4) and offer directions for future research (section 8.5). Before engaging in this discussion, I introduce the chapter by outlining the key concerns of this study.

8.1 Introduction

In this research, I explored the experiences of female migrants from Nigeria working in the British healthcare sector, specifically the NHS, considering how these women make sense of and negotiate their experiences of migration.

I employed intersectionality as a lens for understanding these Nigerian women's lived experiences in the UK because it allowed me to analyse the complexity and multidimensionality of gendered and racialised identities affecting the participants' experiences of migration. This study was also comparative. Although it started with the premise that it was important to look at the shared experiences of Nigerian female doctors and nurses working in the NHS, a central concern was whether professional status mediated these experiences and, if so, in what ways.

By employing an intersectional lens, I drew on Black feminist scholarship, in particular the work of Crenshaw (1989) and McCall (2005). I also drew on Acker's (e.g. 2006) organisational studies approach to inequalities in workplaces, which distinguishes between five organising practices that help maintain inequalities even in the most apparently egalitarian of workplaces (see section 3.4). In addition, in order to study the ways in which identity and experience are shaped by migration, I drew on Hall's cultural studies approach to consider migrant identities as a 'process of becoming'. Finally, I used psychological models of stress-based coping strategies that distinguish between problem and emotion-based solutions (e.g. Lazarus & Folkman, 1985) to provide a framework for my analysis of the coping strategies participants described. These coping strategies were using for the multiple experiences of discrimination they described in relation to the intersections of identities as migrant, Black, African women.

The four frameworks of intersectionality, inequalities regimes, becoming, and problem/emotion-based strategies to stress were used to provide a necessary, novel, sophisticated interdisciplinary and multidisciplinary approach for analysis of the complex and multidimensionality of identity experienced by the Nigerian women in this study. These four frameworks also position this

thesis as taking an interdisciplinary approach that draws on psychology, organisational studies, cultural studies, and Black feminist scholarship to address the complex issues articulated in the following research questions:

Research Questions

1. How do gendered and racialised identities affect the experiences of female Nigerian healthcare migrants working in the NHS?

2. To what extent does professional status mediate their experiences of living and working in the UK?

These research questions were addressed in chapters five, six and seven through an Interpretative Phenomenological Analysis of interviews with 24 Nigerian women (12 doctors and 12 nurses), half of whom were interviewed twice. IPA is a novel method for organisational studies, being primarily used for research in health psychology. In producing accounts that allowed an in-depth analysis of the participants' experiences, this thesis has shown the utility of IPA in other areas of research in which people's experiences and their interpretation of those experiences are central to the research questions. This thesis also developed the methodological design of IPA studies. Firstly, by incorporating a differential factor (difference in professional status) into the otherwise homogenous sample of Nigerian women working as health professionals in the NHS; and secondly by employing a subsequent interview phase rather than the more traditional single-phased interview design. This dual-phase design was successfully employed to more fully address one of the key principles of IPA, that of an in-depth engagement with individual

experience and interpretation of that experience (see section 8.4 for further discussion on this issue). Below, I give a concise overview of my findings, detailing them in relation to the research questions above before discussing how these inform existing literature.

8.2 Overview of Research Findings

I chose IPA as the method of analysis with a view to producing an in-depth, contextualised analysis of participants' lived experiences that also identified the similarities and differences between the individual cases (Smith & Osborn, 2015). It is with this in mind that I presented my findings in chapters five, six, and seven, based on a double hermeneutic approach of my interpretation of the sense-making of these participants of their experiences of working in the UK as Black, Nigerian-immigrant women.

The gendered and racialised experiences of the participants were nuanced. Their gendered experience in relation to emigrating started with decision-making regarding their immigration. For the majority of the participants, this was characterised by a lack of control, structured by their intersectional location as Nigerian women. Participants whose route of entry into the UK was family/marriage-related described the choice to migrate as that of their husbands, while those who entered the UK through the formal education migration route described the choice to migrate as being that of their family. Despite this lack of agency, many participants developed aspirational expectations of life in the UK, particularly around their employment possibilities. However, these expectations were not met, which participants interpreted as a failure that was due to discrimination related their gendered and racialised positionalities.

Experiences of failed aspirations in the early stages of migration were shared across doctor and nurse participants. As Black women working in the NHS, their experiences subsequently differed as they worked in different occupational spaces: nurses worked in traditionally feminised profession, while doctors performed their work in a traditionally male-dominated profession. The historical gendering of their professions structured some of the differential experiences of inequality at work. To elaborate, prior to working in the NHS as nurses, the nurse-participants experienced inequality in the UK labour market, with a lack of employment opportunities based on the intersections of their gender, race and migrant status. In their work as UK registered nurses, the nurses noted that they experienced discrimination on the basis of their racial and migrant identities, but not on the basis of their gender. In addition, racist notions of Africans as having a serving role to British people sometimes also meant that as African women in a caring profession, the nurses' positionality along both racialised and gendered identities were understood as acceptably congruent. Thus, although the nurses had a lower professional status than doctors in the medical hierarchy, they experienced status enhancement by training as nurses, leaving behind their lower-status jobs and taken up a culturally valued role for women in the UK.

On the other hand, the doctors, who had always aspired to being doctors and saw migration as an opportunity to fulfil this aspiration, experienced an exclusionary organisational culture on the basis of intersections between their gender and race. Unlike the nurses, their positionality was not congruent. When their lower status as migrant Black women was combined with their high status as doctors, they were treated in a range of ways that made them feel that they were not recognised as having a legitimate position within the organisation. At work, professional status

thus mediated the effects of racism and sexism in ways that made it more likely for nurses, rather than doctors, to experience a sense of being valued.

Professional status did little to mitigate the challenges participants faced in the home. At home, the women experienced transitional challenges as they tried to continue with a traditional gender role normalised within Nigerian culture while also engaging in the paid work associated with normative expectations for contemporary British women. Thus, while these challenges were gendered in nature – the requirement to take on domestic and childcare responsibilities was associated with being a woman – participants' experiences were the result of their nationality/ethnicity intersecting with their gender, since prioritising the family's needs over the participants' own was understood as the practice of a good Nigerian woman.

The participants thus had to navigate through the cultural landscape of being Nigerian women in the UK, which differed from being women in Nigeria. These negotiations oriented around gendered familial and spousal responsibilities, gendered relations and childcare responsibilities. The dynamics of cultural norms between Nigeria and the UK created a challenge to work out how to still 'do' valued gender practices within the context of long hours of paid employment and reduced paid domestic help. Negotiating the need to take up new women's roles while also inhabiting old ones created several challenges. In relation to what Hochschild (1989; 2003) called the 'second shift', participants had to take up paid jobs while also being responsible for the domestic and childcare work for the family home, requiring them to work long hours that often left them exhausted. Participants also had to negotiate internalised cultural ideas of an ideal woman as being supportive to a man, which problematised notions of female ambition and

success in their own right, and thus their own career aspirations. Migration therefore required these women to navigate new ways of doing femininity and womanhood in the UK.

The process of immigration thus involved a process of becoming as participants navigated new expectations and ways of being. In the early stages of immigration, this process was experienced as a range of shocks, including what I described in the previous chapters as 'gender shock', and 'cultural shock'. These shocks were a response to what the women in this study experienced as discrimination and inequalities based on their ascribed positions that intersected along the axis of racialised, gendered, and immigrant identities. Participants responded to these shocks and their associated challenges by employing a range of coping strategies. Their strategies for managing the second shift at home were often problem-based and included multitasking domestic duties and outsourcing child care, strategies adopted by both doctor and nurse participants. Professional status thus had little or no effect on the participants' domestic responsibilities; having higher status as a doctor did not act as a buffer to the need to perform the second shift. There was only one participant, Beverley, for whom this was not the case. Her professional status and role as the breadwinner intersected with her status as the primary migrant and her husband's willingness to undertake domestic roles, which acted as a buffer to her gendered familial responsibilities (see chapter 7, section 7.2.3.1). Beverley was partly able to do this because her husband did something different (undertaking domestic and childcare roles) to most of the other husbands.

Both doctor and nurse participants had similar emotion-based coping strategies, which included finding social and spiritual support in their families, Church communities, and their faith;

identification with other non-white people who they assumed were also negotiating an organisational culture of white privilege; and a sense of resilience, hope and determination produced through their identification as Nigerian, Christian women. They also took some solace when they saw that white women – particularly the doctors - also had their career aspirations limited.

Where professional status mediated the experiences of these participants was in the problem-focused strategies they used at work. The doctors found themselves being in a stable, internationally recognised occupation but having to navigate a new professional space where they were devalued. Their analysis of this situation lead to their identification of the problem-focused strategies of lengthy (re)trainings and taking on roles in less desired specialisms and/or geographic locations in comparison to their white UK-trained colleagues. Thus, the professional status of medicine enabled the mobility of the doctors, who retained their chosen profession during immigration, but did so at the cost of significant investment in training and an understanding that they would not be offered the same opportunities as their white (or white male) counterparts. In contrast, the nurses lost their previous occupational space as a result of migration and used training to access nursing as a problem-based strategy to reposition themselves in a relatively stable and culturally valued occupational space. Despite this, both doctors and nurses described having to continuously 'prove' themselves as having a legitimate place in the NHS. Examples of this include having to demonstrate legal working status to police called in to address a problematic patient, having patients ask for a second opinion from a white British doctor or request care from a British nurse, and seeing colleagues put forward for promotion despite having less skills or experience.

Overall, the findings of this thesis point to multiple ways in which gendered and racialised identities affect the experiences of female Nigerian healthcare migrants working in the NHS. They highlight the way in which such women are multiply-positioned and demonstrate that these multiple positions intersect in complex ways, often with the outcome that participants experienced themselves as discriminated against through all five of the dimensions Acker describes in her framework of inequality regimes (see chapter three, section 3.4). The experience of discrimination and inequalities at work and home led to participants interpreting their process of becoming as one of surmounting significant hardship and challenge.

The analysis showed that professional status mediated participants' experience of living and working in the UK in some unexpected ways. Being a doctor holds high status worldwide and could thus be expected to protect participants against low status positioning associated with migration, in particular facilitating a positive negotiation of the dichotomy of deserving/undeserving migrant that is based on assessment of contribution to the host country (see chapter three, section 3.1.1). However, for many of the doctor participants, being a female Black migrant doctor positioned them in incongruent ways. This incongruence reduced participants' legitimacy to be understood as skilled people and/or doctors. In contrast, the congruence of being Black, female and in a valued 'caring' profession of nursing allowed nurse participants to gain status both in the organisation and in their wider host culture. However, it is important to highlight that both doctors and nurses experienced an organisational culture structured around white privilege. For example, nurses who aspired to higher status roles within

their profession experienced the same kind of prejudice that doctor participants described. Again, this can be interpreted as the outcome of intersections between sexist and racist understandings that position high status Black women as incongruent. See table 8.1 below for a summary of these findings.

Table 8.1: Summary of thesis findings

Sub-ordinate theme	Key experiences	Gendered dimension	Racialised dimension	Inter-sections of gendered/ racialised identities	Mediation by profession al status
Becoming a Nigerian woman in the UK	No agency in decision to immigrate	Yes, intersecting with African/ Nigerian identity e.g. *African culture can be very patriarchal* (Vicky)	None	Yes. Ethnicity intersecting with gender.	Little
	Needing to do the 'second shift''	Yes, intersecting with African/ Nigerian identity *e.g. everybody has to work*' (Helen)	None	Yes. Ethnicity intersecting with gender.	Little-none
Becoming a migrant	Others' perception of immigrants as incompetent	Not gendered	Yes. Not seen as an individual but Africans. '*all these migrants they don't know what they are doing*' (Beverley)	Not intersecting	Little. Both experience devalued identities, but doctors able to remain in chosen profession.
Becoming Black in Britain	Being 'othered'	Not gendered	Yes. Ethnicity '*where you are originally from, hmm, even if you are British'* (Mary)	Not intersecting	Little - none
Finding new work identities	Downward mobility	Not gendered	No. '*My first job in the UK even though I was a doctor was to deliver leaflets into people's houses*'	Not intersecting	Little – none
Disadvantag ed in the labour market	Dis-preferred identity	Yes, gendered	Race. '*I did my nursing back … in Africa… I am a black woman… my nursing was a diploma*' (Gail)	Yes, intersecting	None
	Overseas qualification	Not gendered.	Nationality. '*having a*	Not intersecting.	None

			qualification from a different country, it makes it very difficult for you to get jobs' (Cathryn)		
A squeeze before the top	Marginalised	Not gendered	Racialised. '*the higher you go the less Black and ethnic minority group that you see*' (Winnie)	Yes. Race and ethnicity intersected.	None
Work as challenging because of routine racism	Feeling of vulnerability	Not gendered	Yes, racialised. '*If you're fortunate, it's to find someone who sees you beyond your colour*' (Gail)	Not intersecting.	None
	Fear of litigation	Yes, gendered	Yes, racialised.	Yes, race and gender (*Being a Black woman, coming from a different country, and the way they litigate*(Karen)	None
	Prove oneself	Yes, gendered	Yes, racialised	Yes, intersecting. '*I have to prove myself… she is a fat, Black woman, the three negative*' (Jennifer)	Yes
Navigating barriers to good employment	Repositioning	Not gendered.		Yes, migrant status intersection with ethnicity. '*I went into nursing because I couldn't get a job in the other field*' (Sharon).	None mediating role for the nurses.
	Conscious positioning (specialism)	Yes, gendered, intersecting with migrant status.	Not racialised.	Yes, gender intersecting	Little, allowed the doctors to

		'the consultant post is virtually impossible as a migrant and as a female' (Quincy)		with migrant status	remain in the medical profession, but in a different specialism than desired one.
	Conscious positioning (regions)		Yes, migrant identity intersecting with nationality. '*those areas open doors for foreign nationals, immigrants*.' (Jennifer)	Ethnicity intersecting with migrant identity.	Little, allowed the doctors remain in the medical profession but by relocating
Seeking resources for managing the impossible	Outsourcing childcare	Yes, gendered. '*in Nigeria where I didn't have to do those things, you have help*' (Irene)	Yes, nationality.	Yes, gender intersecting with nationality.	Little-none
	Flexible work time	Yes, gendered.	Yes, nationality	Yes, gender intersecting with nationality.	Little – none, work-family balance available option with nursing through agency work.
Emotional strength	Strength through faith	Not gendered.	Yes, ethnicity-related. '*I am a Christian, and I really depend on God*' (Jennifer)	Not intersecting.	None
	Building your own resilience	Not gendered.	Yes, nationality	Not intersecting	None.

8.3 Key Contributions to Research

This thesis has made an original contribution to research in numerous ways, in part thanks to its interdisciplinary approach, informed by a feminist standpoint that incorporated organisational studies, psychology, and cultural studies theory. This interdisciplinary approach has allowed an in-depth analysis of participants' experiences through the lens of different frameworks, thus defining the entire journey of the 'process of becoming', from the decision to migrate to becoming gainfully employed in a professional space. Furthermore, the thesis revealed the process of becoming as being structured by inequality regimes and intersectionality, with one of the original contributions of my thesis being the introduction and exploration of professional status as one such axis of difference.

8.3.1 The Process of Becoming: Intersectionality and Inequality Regimes Perspectives

In chapter three, I outlined the cultural studies conceptualisation of identity as multiple, fragmented, and context-based (Hall, 1996a). I discussed the emergence of multiple new identities as the result of a wider process of change in the social world, the result of the immigration process (Hall, 1996a), and the likely impact of these new identities on the immigrant experience in creating a process that de-centred and fragmented the identity of the immigrant into multiple new identities that were raced, gendered, and ethnicised, and which positioned immigrants as 'others'. This refers to the positioning of people that is based on their cultural and national historical backgrounds and their different rankings in the world economy (Hall, 1997a). As members of multiply stigmatised and disadvantaged groups, Black women are thus socially located in multiple positions of marginality and subordination (Hall, 1997a). While

the outcome of the interaction of these culturally ascribed characteristics can potentially be discrimination and inequality, Hutnik (1991) and Aboud (1988) argued that developing new acquired characteristics may allow people with low ascribed characteristics to increase their overall status. This was the rationale for exploring the role of professional status in mediating the experiences of Nigerian women living and working in the UK.

Chapter five focused on the superordinate theme the 'process of becoming' and highlighted questions around 'who we might become', rather than on 'who we are' or 'where we came from' (Hall, 1990, 1996c). Hall (1990) argued that cultural identity is a matter of 'becoming', one that belongs to the future, as well as a matter of 'being', thus belonging to the past. The experiences of the participants discussed in chapter five suggest a 'process of becoming' that supports Hall's postulations that identities are not fixed, but undergo a constant transformation which is embedded in history, representation, and language. In chapter three, I outlined how the racial category 'Black' is represented as inferior (Tsri, 2016) and how the negative belief and stigma associated with Blackness is underpinned by historical developments such as colonisation (Hall, 1996c; Howarth, 2006), with the outcome that Black is structurally positioned at the bottom of the hierarchy. Furthermore, Hall (1997a) maintained that Black is a historical, political, and cultural category, and through the use of signifiers that point to certain historical moments, the inscription of these histories (in the past) are read in the Black skin. From this standpoint, language, history, and representation structure the experiences of Black people. In the medical profession, female migrants can also experience deskilling, marginalisation, and gendered power relations (Kofman, 2000; Wojczewski et al., 2015), with recruiters preferring white males to Black or white females (Acker, 1998, 2006; Farmer, 2016; Puwar, 2004). Such inequalities

affected the daily practices of participants, and so intersected with Hall's reference to historical events such as post colonialism. For example, having to take an English test erased the participants' English-speaking heritage produced from Nigeria and Britain's colonial relationship.

Acker's (2006) inequality regimes were conceptualised as an intersectional analytical tool to consider the ways in which organising practices and processes maintain inequalities in the workplace. This thesis shows how inequality regimes and cultural studies can be usefully brought together to explore how language, history, and representation structure the experiences of Black people in the workplace in ways that facilitate inequality. For example, the narratives of participants showed a continuation of Blacks as associated with slavery and servitude (an association from history), in which Black people cannot be imagined in respected roles or expected to be good at their jobs, nor as able to produce high quality work.

Acker's framework was also useful in making visible the inequalities that participants in this study described. All of the five inequality practices identified by Acker were narrated by the participants. For example, participants encountered discrimination in recruitment and hiring practices. One participant (Sharon) was told that her application would only be considered *'if they can't get a British'* person. The use of Acker's inequality regimes enabled the analysis to explore ways that inequalities work within organisational structures committed to equal opportunities, highlighting directions for how NHS organisational procedures might be developed to reduce inequalities. Using professional status as an intersectional axis also allowed

the thesis to contribute to understanding how professional status mediates some but not all of the discrimination levels that Acker describes.

While professional status mediated some forms of the discrimination experienced by participants, the thesis showed that in the process of becoming, their professional identity and status (*who* they became) was structured by processes and practices that produced and maintained inequalities (inequality regimes) based on the interaction of their racialised and gendered positions. As discussed, the inequalities they encountered were perceived by participants in this study as embedded in history, representation, and language. Hall and other cultural studies theorists use the process of becoming, "as a useful starting point for thinking about subjectivities" (McLeod & Yates, 2006, p.77), but their work is not usually empirical. Thus, a novel contribution made by this thesis is to support Hall's theoretical framework as an important way of conceptualising migrant experiences, while also developing that framework by showing how professional status can mediate this 'process of becoming'. This research has therefore not only supported Hall's theory of the process of becoming, but in adopting an intersectional lens and Acker's inequality regimes, has also highlighted how organisational practices and processes, and the interaction of multiple identity categories, define and shape the experiences of immigrant women in the workplace.

The thesis has also contributed to migration literature that has evaluated how the immigration process could potentially alter identities by the construction and reconstruction of new identities, thus highlighting the centrality of identity in the migration experience (La Barbera, 2014). Rose's narrative on becoming Black represents a perfect example of the reconstruction of new

identities; Rose was uncertain of how to identify herself as Black or coloured (see chapter 5, section 5.2.3) and expressed a concern about this new identity which was non-existent prior to migrating. In addition, by considering the migrant stories in chapter five through the lens of 'becoming', this thesis has shown the utility of the 'becoming' framework for exploring identities in flux. In addition, another novel development was made through explicitly tying the intersectional approach to understanding migration as a process of becoming, which had the advantage of explicitly examining, and thus demonstrating, the dynamics of multiple positionalities in this process.

8.3.2 An Intersectional Feminist Approach to Migration Research

I discussed theories of migration in chapter two, outlining the numerous theories that study the patterns and trends of migration as well as its outcomes. Further, I highlighted the neglect of women migrants in these theories and explored how their experiences could potentially have differential outcomes from those of male migrants (Kofman, Raghuram & Merefield, 2005; Kofman, 2011). Chapter two therefore argued that traditional theories of migration have mostly neglected the influence of race and gender in the migration process. Focusing on an economic cost and benefit model of migration, these theories often assumed men to be the primary migrant, relegating women to being accompanying dependents with no economic role who were absent from skilled migration (Boyd & Grieco, 2003; Kofman, 2000, 2012; Kofman, Raghuram & Merefield, 2005).

However, such traditional theories of migration are at odds with contemporary gender-differentiated statistics which reveal that women are observably present in all labour migration routes, and that there has been an increasing feminisation of labour migration (Hondagneu-Sotelo, 2003; Parreñas, 2005). Adepoju (2005) highlighted an unprecedented shift when she identified professional Nigerian women who had migrated independently, leaving their husbands with the children. This practice was found in one of the narratives of a participant of this study (Beverley), who acted as the breadwinner while her husband took up childcare responsibilities until the family was in a position to revert to a dual-earner family. However, this participant was unusual; the majority of the participants aligned with the statistics of the 2011 UK census which highlighted that most of the Nigerian women who migrated to the UK did so under the family-related migration route, accompanying or joining spouses, or through the student route. However, the census data provides no rationale for these practices. Nor do many theories of migration. For example, Kofman (2000) expressed concerns that migration theories about skilled migration into Europe render skilled women migrants' invisible. By putting women's experiences at the forefront of the research, this thesis therefore addresses an important gap in understanding.

The majority of the women in this study who migrated to join their husbands described the decision to migrate as being based on cultural expectations of married women to join their husbands in any geographic location. This finding supports that of Watts (1983), who stated that the geographic location of Nigerian wives is based on their husbands' geographic location. However, the current research develops this further by showing the lack of agency and choice of women in the migration decision-making process. This has also shown the continuity of such

gendered practice and gender relations for Nigerian women, despite significant change, since Watts was writing in the 1980s, more than 30 years ago.

This research further develops the work of Watts by showing not just a lack of agency but also how the women make sense of this lack of agency. Many of the participants saw this lack of choice as an effect of inequality; it was not talked about in terms of pleasure in fulfilling gender roles (pleasure that was seen, for example, in some of their talk of taking care of their husband or children), but as a burden of women within a patriarchal society. This lack of agency in the migration decision-making process highlights how gendered and national identities intersected for Nigerian women, even while they simultaneously held aspirations for their individual careers and described a number of agentic strategies when dealing with the challenges of immigration. In identifying such complexity, this thesis supported Kofman, Raghuram and Merefield's (2005, p.7) suggestion that the study of migration should include an intersectional perspective in order to understand outcomes of the "complex matrix of migration". It did this by demonstrating how the migration outcomes of these female skilled Nigerian migrants, who migrated through various routes including the family-related route, were shaped by their intersectional positionality as married Nigerian women.

The focus on the complexity of migrant women's experiences in this thesis also addresses important gaps in research on the work experience of skilled female migrants who accompany male labour migrants as well as the potential difficulties they encounter in trying to access professional or skilled work and the strategies they employ in navigating the labour market (Kofman, 2012). Before this thesis, the literature was limited to a few studies. These include

Evans et al.'s (2005) study with Nigerian women living in London who held graduate and postgraduate qualifications but worked as cleaners due to the saturation of the highly skilled labour market in London. Other studies supported this finding, showing that Black African and Black Caribbean women have difficulty securing professional and managerial jobs despite having appropriate higher education qualifications, with the outcome that they had lower earnings than their white colleagues (Clark & Drinkwater, 2007; Oikelome & Healy, 2007).

Building on these studies, the present research's use of an intersectional lens revealed the presence of skilled women amongst the reunification/family-related migration route. It also contributes to the understanding of the experience of skilled female migrants who accompany male labour migrants in terms of challenges to and strategies for gaining professional employment. Participants narrated a series of challenges encountered in navigating the UK labour market as skilled migrants. These participants assessed their gendered, racial, and immigrant identities, as well as their overseas-qualifications as barriers to accessing the UK labour market, and sought to alter the problem of their diminished employability by enhancing their status through effortful achievements. Participants described having to identify new work opportunities instead of those they had hoped for, be that training into new professions (nurses) or sustained attempts to enter medical training as doctors (see chapter five).

Participants assessed their diminished professional status by mediating their experiences as first-generation migrants and sought in a variety of ways to enhance their status through professional development. This finding contributes not only to the migration decision-making process in

international migration theories, but also to an understanding of the labour market experiences of Black immigrants from an intersectionality perspective. International migration theories need to recognise the ways in which migration is mediated by gender, and race/ethnicity, as women are increasingly likely to be the economic driver, but in complex ways, for example within a framework of patriarchy. This research also adds to existing literature on the experiences of female migrants working in male-dominated sectors in the UK and how their experiences are structured by their gender and race.

Chapter six focused on the superordinate theme *'inequalities at work'* and unveiled participants' experiences of inequalities produced through their positioning in relation to their gendered, racialised, and ethnic ascribed identities. Building on Acker's inequality regimes framework, this study offers support by providing evidence of the intersection of race and gender in the NHS, as well as those processes and practices that create and maintain inequality in the NHS. The organisation of work facilitated the production, reproduction, and maintenance of gendered, racialised, and intersectional inequalities. Furthermore, it highlighted recruitment and hiring practices that created and perpetuated inequality in the NHS. Winnie and Quincy (see chapter six, section 6.2.1) narrated limitations encountered by female migrant doctors, as they found the design of the training hierarchy to be highly discriminatory; they were having to access six-monthly cycle jobs while their British counterparts had two-year roles. This six-monthly cycle subjects Black women migrants to discrimination over and over again, as they seek employment opportunities and compete with their white counterparts. Karen and Quincy showed how they worked twice as hard for fear of litigation which, according to Acker (2006), acts as a form of internalised control which is invisible, unwritten, and thereby hard to challenge.

Equally important is the contribution of this research to offering an interpretative framework for data on Nigerians in the UK 2011 census statistics. The UK 2011 census revealed that Nigerians had the second highest proportions of 'level 4 and above' qualifications in comparison to the UK-born population, irrespective of length of residency, and that Nigeria is one of six countries with very high English proficiency levels. However, it also showed that Nigerians in highly skilled professional occupations ranked eighth in position relative to other countries, a figure which more than doubled in number for those with more years residing in the UK. The present study offers empirical evidence on the experiences in participants' work and home lives that underpin these statistics. The women in this study were well-educated, many at postgraduate level, and had high proficiency in English language, yet those who were not doctors (and thus part of a globally recognised profession) were clustered in unskilled, low waged jobs unless they retrained as nurses. While those who were doctors required significant retraining, an aspect they might have looked forward to, since working in the UK was associated with skill development. However, the retraining requirements were combined with a lack of recognition of their skills, such as English language, and so produced an experience of being discriminated against because they were Black women, in the context of historical stigmatisation of African people. This study therefore reveals that while female migrants may gain entry into the UK as skilled dependents of primary migrants, they experience significant challenges attempting to enter the UK labour market.

This research adopted an intersectionality lens in framing the complex interaction between race, gender, and professional status. Performing an intersectional analysis using racialised and

gendered identities with professional status is novel, and was undertaken by adopting an intercategorical approach to intersectionality. McCall (2005) proposed three methodological approaches for studying intersectionality: the intercategorical, intracategorical and anticategorical approaches. The intercategorical approach was adopted as it helped answer the research questions and the aims of this study, exploring participants' experiences by using existing categories (Nigerian, woman, migrant).

McCall (2005) argues for the usefulness of studying existing analytical categories in order to document relationships of inequality along multiple and conflicting dimensions. By adding the novel existing category of 'professional status' to the study of immigrant women, the thesis combined McCall's intercategorical approach with Acker's inequality regimes, allowing for a comparative analysis between Nigerian women migrants with different professional statuses in the same national organisation.

Both Acker and McCall recognise the importance of intersectionality in studying women's experiences because these are structured by women's multiple positioning. Thus, an intersectional approach using existing categories to explore how professional status might mediate the 'process of becoming' and experience of inequality regimes allowed the thesis to explore the complex patterns in participants' experiences. For example, Black African female nurses aligned with wider norms/expectations that led to less experiences of racism than did the doctors. This approach was therefore valuable in documenting the differential experiences of inequalities between doctors and nurses, as the professional status of the doctors mediated the experiences differently than it did for the nurses as they navigated the UK labour market. The

doctors acknowledged that while they experienced discrimination on the basis of their race and gender as they attempted to access the UK labour market, their professional status as doctors (that provided, for example, global recognition/labour mobility) mediated their experience and granted them access to the medical profession in the UK. In contrast, nurses experienced discrimination on all three counts as their gender, race, and professional status intersected and mediated their access to professional, highly skilled jobs and socially located them at the bottom of the labour market hierarchy, giving them access only to low skilled/unskilled, low-waged jobs. Their strategy for gaining access to skilled professional jobs was to retrain as nurses. The intercategorical approach to intersectionality helped to document relationships of inequality along multiple dimensions of existing analytical categories, thus contributing to existing organisational research. The thesis thus points to the importance of an intercategorical intersectional approach for understanding the experiences of migration, as well as the importance of considering the way professional status may mediate some but not all of these experiences.

8.3.3 A Coping Strategy Perspective to International Migration Research

Reviewing the dominant theories of international migration uncovered significant gaps in the literature, in particular, the coping strategies employed by female immigrants for responding to obstacles and hardships they encountered in accessing employment opportunities (Kofman, 2012). A focus on the economic contexts of international migration meant that migration theories often failed to engage deeply with important psychological aspects of migration, such as understanding gendered identities and coping strategies. The integration of feminist theory into migration studies has highlighted the existence of skilled females migrating through family

routes, such as marriage-related, accompanying spouse, and reunification routes (Kofman, 2000, 2012; Kofman, Raghuram & Merefield, 2005; Raghuram, 2004, 2008).

Contributing to this developing body of work, this thesis approached international migration from an intersectional perspective and showed that Black African women experience stressors such as sexism and racism at work, and a transfer of these stressors from work to the home and vice versa. For example, having to work long hours in paid employment meant that also having to do the second shift of domestic work at home left the participants tired for their paid work. Doctors, in particular, felt this was producing inequalities at work since they did not start at a level playing field with men or white women who, they imagined, had domestic support from their partners.

Responding to multiple challenges at work and home, participants employed a range of strategies that aligned with the psychological literature that distinguishes between problem-based and emotion-based solutions. This range of strategies allowed participants to respond to stressors flexibly. For example, those participants who experienced deskilling as a result of the intersections of their gender, race, and overseas qualification employed problem-based strategies by reskilling as UK-qualified nurses, repositioning themselves with their acquired identity and status, thereby enhancing their professional status. Employing problem-based solutions at an individual level as a response to what was perceived as organisational problems allowed these women to negotiate a path through the organisational structure, but left the system unchanged. There were few exceptions to this type of strategy, and only one with a successful outcome. This participant was Quincy (see chapter seven, section 7.2.1.4), who employed a confrontational

strategy that had positive outcomes for herself but also helped bring about change in the litigation process and procedure of the UK General Medical Council, creating an outcome (in her words) with a positive impact on other migrants in similar situations.

Chapter seven focused on the superordinate theme of coping with threatened identities, describing a number of problem-based and emotion-based coping strategies employed by participants, the understanding of which offers further contribution to knowledge around immigration and migrant experiences of negotiating new organisational cultures. Of particular note is that by taking an African-centred cultural perspective to traditional psychological stress coping literature, the thesis showed how religious practices and African identities intersected in ways to produce both emotion and cultural-based coping strategies. This finding supports research identifying the importance of religion for African Americans coping with stressful situations produced by sexism, racism, and/or gendered-racism (Shorter-Gooden, 2004). For example, Shorter-Gooden (2004) explained that African American women need many coping mechanisms because of the multiple discriminations they encounter daily, more than Black men or white women. The findings of the present study concur with this claim in relation to migrant Black African women in the UK. These participants described successfully managing a range of stressors and oppression in order to diminish negative impact on their psyche and health, including spirituality and national identity-specific resilience. For example, as Sharon said, "We are Nigerians, we kind of survive in any condition" (see section 7.2.3.4). Thus, as well as identifying and exploring the range of challenging experiences participants described, the thesis was also able to show the breadth of strategies that these women employed to foster resilience during difficult times.

These findings supported the coping theory from an immigrant perspective by considering the contextual aspects of how Black women in the UK might mobilise problem- and emotion-based coping strategies for stress. My research adds to existing literature which suggests that immigrants need more coping strategies, in part because of discrimination experienced in the labour market, demonstrated by the ways in which participants responded to employment discrimination through repositioning and conscious positioning in the labour market. Furthermore, participants experienced discrimination as Black women in multiple ways and developed understanding of how their coping needs to align psychological theory with cultural sensitivity. This thesis thus illustrates the contribution of coping theory from an international migration perspective.

8.4 Research Limitations and Post-Analysis Reflections

This research was conducted to investigate the mediating role professional status played in the gendered and racialised experiences of Nigerian women working in the NHS. I made the decision to treat these Nigerian women as a homogenous group, understanding this position as advantageous for examining their experiences as a group at neglected point of intersection. I felt that it was important to recognise and explore the shared experiences of female Nigerian healthcare migrants working in the NHS. This decision is supported by the findings, given that so many of the key experiences were shared by both doctor- and nurse-participants, and that many of the participants attributed their experiences to their gendered and racialised identities in the wider context of identifying as Nigerian and/or African (see table 7.1). Smith et al., (2009)

states that "IPA researchers usually try to find a fairly homogeneous sample…and the extent of this homogeneity varies from study to study" (p.49). Hence, my findings suggest there was enough homogeneity to meet the requirements of a high-quality IPA study. The development in IPA methodology to explore differences within such a group via professional status also allowed relevant differences to be explored, further developing understanding of Black women's experiences of immigration.

However, during the analysis other factors emerged as also creating differential outcomes in experiences between participants. These included differences in the number of children, or family type, and marital status of these women. For example, the one participant who had a husband who contributed significantly to the domestic work of the family described a differing experience and associated coping strategies. Where possible, such differences were acknowledged in the analysis.

Another potential limitation of the study with reference to homogeneity is that I chose to look at two groups (doctors and nurses) together as I made an important methodological decision to expand the use of IPA to include participants who were known to have differences, in this case two groups of healthcare professionals, doctors and nurses. It was also useful to divide the sample into doctors and nurses, so that the phenomenon (professional status) can be understood from more than one perspective (Smith et al. (2009). In this study, the findings showed the shared experience of challenges in accessing the UK labour market, but also highlighted the mediating role of professional status in producing some differences between the two groups of healthcare professionals. While the doctors remained in medical profession, due to its

distinguishable global reputation, most of the nurses retrained to become nurses as a means to good employment in the UK. Another example was the way that being Black, female and a nurse was seen as a congruent occupational positionality allowing the nurse participants to feel valued, more so than the doctors who described their high status medical professional position as being read by others as incongruent with being a Black woman. Designing this comparative study thus worked to highlight the mediating role of professional status. However, the skilful task of weaving through and between the two groups was challenging, and it is possible that an analysis which looked at the two groups separately from the beginning would have developed a greater understanding of their different experiences.

A post-analysis reflection of this research highlights further consideration of the sample composition in terms of the women who answered the research call. The aim of the thesis was to produce an in-depth qualitative study and I therefore chose IPA as a research method since it focuses on small and purposive samples to produce a rich and detailed account of participants' experience of the phenomenon. I further developed depth by conducting a two-phased data collection process and incorporating a mixed-method interview approach (unstructured and semi-structured) to this qualitative research. The findings are thus transferable in terms of articulating important aspects of Nigerian women migrants' experiences, but they are also limited. In particular, analysis points to the women in this study as characterised by being highly agentic, given that they continuously sought out employment opportunities in difficult circumstances not of their own making. Thus, despite the challenges they described facing, they offered progressive narratives. Other experiences of the migrant Nigerian women population in the UK also need to be examined, including women who are less agentic or less able to successfully draw on the

range of coping strategies evidenced in this study. Gail in the extract below, for example, indicates that such women exist and whose stories have thus not been told:

> "*I was fortunate to be among the four that graduated. I'm not saying I'm any better than the girls that left because I know that in actual fact I'm not any better than those other black girls that left or that were sent off eventually*".

Many of the nurse participants in this study were able to choose nursing as a route to higher status employment because this training was funded by the government at that time and they were therefore able to contribute to the family income while studying. However, changes to government funding for immigrants (free tuition and bursary while they studied) was stopped in February 2003, thus potentially closing off this route for subsequent Nigerian women seeking ways to enhance their status and access 'good employment'. Thus, in recruiting women able to describe a long time in the UK, the sample therefore was limited to those who had had access to funding that no longer exists.

Post- analysis reflections also require me to further consider my own positionality and its impact on the data. As a researcher, my insider role as a Nigerian migrant woman was a significant benefit. I had worried that the Nigerian culture of 'putting on a brave face' would lead to participants only telling me positive experiences about their lives. However, this did not happen. Participants told me about their challenges, and often suggested in the interviews that they were able to tell me about them because I was also a Nigerian woman, so I would understand. However, I was an outsider in relation to their experiences of working in the NHS, and this was a limitation in terms of being able to ask relevant questions that perhaps an insider would have considered, thus reducing insight into participants' experiences of the organisational culture. On the other hand, my outsider status meant I had procedures explained to me that an insider would

have taken for granted, giving me the opportunity to examine their experiences from an inequality regimes perspective.

Smith and Osborn (2009) recommend the use of small samples in IPA studies to enable in-depth, detailed, and comprehensive case-by-case analysis. While it is a less common practice to use large sample sizes, this study used a larger sample size of 24 participants. I made the decision to further increase the dataset by interviewing some participants twice. These second interviews were done to maximise the depth of the data, and to address the research questions, given the justification for studying Nigerian women in health care together, as well as the justification (from literature and to a certain extent findings) to look for mediating effects of professional status. However, IPA literature suggests that larger sample sizes can lead to more shallow or less engaged analysis (Smith et al., 2009) and indeed I did feel overwhelmed at times. However, this was a long-term, PhD research project, and so I could work through this feeling, following IPA analytical procedures in a systematic and iterative way, so that over time I was able to develop a rich, conceptual understanding of participants' experiences. In addition, this justified the use of a smaller sample in the second phase.

Further, those working with IPA also argue that the expansion of sample size may hold opportunities for the method (see appendix C - J. Smith, personal communication, June 29, 2018). Thus, within psychology there is experimentation, and outside of it in my other 'host' discipline, business and management, there are also developments, including the use of

comparative research designs. Given that I was building on and developing these innovations, my study therefore aligns with these multiple developments.

Despite working hard to create a design that facilitated the collection of in-depth qualitative data, participants were 'time-poor', meaning their accessibility was a limitation of the study. The multiple work-related and familial roles of these participants, coupled with the long hours associated with their jobs as nurses and doctors, limited their availability to participate in the research. On some occasions I was prompted to stop the interview early due to time constraints or to conduct an interview interrupted by family interactions, such as a mother attending to a crying child or family business, or being interrupted by phone calls from family members. This is a possible outcome of working with under-researched populations. Such participants are often hard- to- reach for particular reasons, such as being time-poor or more marginalised. Thus, while these interviews may not have yielded the richest data at times, the time I had with the participants was important for developing the field.

8.5 Directions for Further Research

This thesis has shown the utility of taking an intersectional approach to the study of Black women migrants working in the NHS as doctors or nurses. The thesis points to a range of discriminatory practices experienced at home and work, which could be the starting points for future research on how the NHS can develop more equitable organisational structures. For example, Acker's inequality regimes can be drawn upon to examine how Black African migrant health sector workers might be better supported in the organisation. This is likely to include

training for these women (for example, a better understanding of the education and health care system so that they can make more informed choices in their training) but more importantly, training for those giving the training and providing employment opportunities, so that they can develop their practices in ways that are more inclusive. A central future challenge is that of understanding how organisational structures aimed at producing the best doctors and nurses (such as competitive training) can work alongside inclusive organisations.

Immigration status was almost always an important a factor for the Nigerian women in this study. Immigration mediated their gendered and racialised experiences in the UK. Linguistic difference, in terms of having a foreign accent, was identified as a factor that influenced perceptions others had of these participants as lacking in knowledge and skills. The statistical figures of the UK 2011 census demonstrate that there was a higher proportion of Nigerians in the highly skilled employment sector for those with greater length of residence, and that Nigerians included a high proportion of people with level 4 or more qualifications, and high proficiency in English language. Considering these factors, future research on gender taking an intersectional approach could explore the experiences of second-generation Nigerian immigrants working in the NHS as well as looking at other healthcare occupational workers, thereby expanding the scope of the research. That is, future research could take a longer temporal viewpoint and explore the process of becoming for NHS migrants over generational shifts.

The thesis also points to other important experiences to be examined. These include asking what the process of transition is like for Nigerian women who have worked in the UK but who return

to Nigeria. Do these women experience another 'gender shock', and if so, how do they negotiate it? Similarly, what transitions along the intersections of racialised and gendered identities do the male partners of Nigerian women working in the UK experience? Are there transitional challenges that these men experience which could be used to leverage more equality for their female partners? Finally, much of 'race' research focuses on Black experiences. While it is important that these experiences are investigated, critical race studies could be further developed by exploring the way 'whiteness' also structures the migrant experience, so that whiteness becomes a category to explore, rather than being taken for granted.

8.6 Final Conclusions

Despite significant healthcare sector migration to the UK, little research has explored the experiences of African women who migrate to the UK and work in the NHS. The present study sought to address this gap with an in-depth analysis of female Nigerian doctors' and nurses' experiences of emigrating to the UK and subsequently taking up employment in the NHS. The thesis described a process of becoming in which migration was characterised as being driven by the demands of global economic capitalism and local patriarchal norms in which women followed their husbands' or family wishes. Migration to the UK itself was characterised by shock: gender shock, and culture shock, requiring participants to learn to understand themselves in new ways that often located them in multiple dis-preferred positions.

Participants employed a range of problem and emotion-based strategies to cope with the stressors produced by these shocks, retraining in a variety of ways so that they could have access to

employment where they had value and which had value for them. However, their experiences of employment as nurses or doctors was structured by multiple patterns of intersecting inequalities and discriminations based on their gendered and racialised identities. Overall, their experiences were thus characterised by significant challenges and by a drive to exert agency and choice in contexts not of their own making that were often experienced as limiting.

The thesis highlights the value of taking an interdisciplinary approach to study the way that gender and race structure experience. It brought together cultural studies theories of belonging with feminist organisational and methodological work regarding the importance of an intersectional approach to the study of inequality regimes and women's experiences more generally. Finally, it showed the utility of using psychological theories of coping with stress within an intersectional approach that is sensitive to the way that gendered and racialised identities might structure the experiences that occur when deploying these strategies. Overall, the thesis highlights the way inequality regimes can exist in organisations committed to equal opportunity employment practices and where future work can be directed with the aim of creating more inclusive organisational cultures. Finally, it points to the utility of considering professional status as an important factor in mediating successful pathways for Black female immigrants in the UK seeking to enhance their lives through migration.

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Appendix A – Transcription Notation

INTONATION

Words spoken with rising intonation are followed by a question mark "?" Example: you know what I mean?

Words spoken with falling intonation are followed by a full stop "." Example: that's when I came to the UK.

EMPHASIS
Words spoken with emphasis are shown with capitals letters. Example: And RACE, I guess can be an issue

PAUSES
Short pauses (less than a second) are shown with a comma ','. For example: I had to do, erm, go below my standard.

Longer pauses are shown with three full stops '…'. Example: *Nigeria … Decision to come here?*

Words omitted are shown by (…). Example: *there are regulations and rules (…) especially having a qualification*

ADDITIONAL INFORMATION

Information to add to reader's understanding of what the participant was talking about or how the participant expressed it are given in square brackets '[]'. Example: *they [British colleagues] tend to generalise, all these Africans, migrants*

Information to add to reader's understanding of how the participant expressed their talk are given in round brackets '()'. Example: *(laughs out heartily)*

Information on the interviewer's interjection are given in square brackets '[]'. Example: *sometimes their husbands are stay-at-home dads, taking care of the kids, do you understand, [int.: house-husbands as they call it]?*

When participants used active voicing (speaking as if they are repeating back an actual conversation) quote marks are used " ". For example, *and then I am like, "why do you assume I am from somewhere else, what do you mean by originally?"*

An example of an interview transcript using this notation is given below.

Int.: Thank you for your time today. This will be erm, a very short interview, just to know a bit about how you came to the UK.

Beverley: Ok, I came to the UK to further my education, I was already trained in Nigeria as a medical doctor, but I wanted to train in, erm, general practice, family medicine, which wasn't available, back then, then in my home country. So that is why I came to the UK, [int.: alright].

Int.: And what were you doing before then?

Beverley: I was working as a doctor

Int.: Why did you make the decision? Well, you said to further your study.

Beverley: Yes, what I wanted to do wasn't available then, I, I understand they have it now, but then they didn't have family medicine.

Int.: And what did you feel at the time, did it meet your expectations of what you thought about the UK, or was it below your expectations?

Beverley: Umm, you mean coming here? [int.: yes]. It was fine, yeah, it met my expectations I would say

Int.: Okay, we will just go through this words, you can choose any or all of them, anyone you want to speak about, WOMEN, RACE, GENDER, irrespective of the subject area.

Beverley: So I will just start here, WOMEN, erm, I believe women have a lot to contribute, but we are faced with many challenges, you know. We have to juggle family and work, again the bias against women also, some employers may feel a woman will get pregnant and leave with maternity pay and so on. So it is navigating through all that and still be able to move ahead with your career, is a big problem for women. And also coming from our background, also women are not expected to be so forward-moving, you know, even friends will tell you that it will affect your family, ah and, you will have problems with your husband and so on. So we are sort of, discouraged from really reaching to the top, so to speak. And that can be a problem if you are the kind of woman who wants to reach to the top. So you might find that you are actually drawing yourself back, not letting yourself to fly, to do all the things that you'd like to do. And RACE, I guess can be an issue, if you are black you may feel at a disadvantage, you might feel people are looking down on you. The society thinks, mmm, you are black, what can you do? So that can affect some people's self-esteem, [int.: yeah]. For me, I think I have been fortunate because I am not moved by those kinds of things, you know. When I came here, we were so few, black people, you know, everywhere I went to, in the hospitals, in our different teams, I was the only black

Appendix B: Audit trail (example of data reduction/analysis note)

Descriptive Summary

SE came to the UK because she felt she had better career prospects here. The UK was more advanced in medical terms than in Nigeria, and she is opportuned to see medical and diagnostic equipment, which in Nigeria she heard about but never saw (**page 1; lines 4-9**).

Completion of formal medical training in medical school and one year of foundation level prior to coming to the UK (**page 1; lines 13-15**).

The basis for SE's decision to come to the UK was hinged on becoming a better doctor and aid her family in Nigeria financially (**page 1; lines 17-19**).

SE was extremely excited when she had the opportunity to be in the UK, and she was quite optimistic about the future and eager to start off her advancing her career here in the UK. However, her experience did not match her expectations (**page 1; lines 21-22, 24**).

SE experienced a downward mobility in order to enter the system, by starting from the foundation level which she had completed in Nigeria prior to coming to the UK. Everything was new and it took two challenging years for her to get into the system. She started with a training post though she was not being trained, and this also meant working with people who she felt were below her level of training prior to coming to the UK (**page 1; lines 26-34**).

SE migrated to the UK because she felt disappointed and let down by her country Nigeria, who has not provided her with the basics such as security, adequate education and training, so as to give her a platform to succeed and gain access to the world (**page 2; lines 1-7**).

SE is now a qualified GP, though it took longer than she had expected and a lot of stress was involved in her journey to becoming a qualified GP in the UK (page 2; lines 9-12).

SE attributed her slow progress to the fact that she did not do her formal medical school training in the UK, and this hindered her knowledge of how the system works. As a result of her limited knowledge of the system, she moved from one specialty, O & G, due to its potentially stressful nature to her and her family, to another specialty, general practice. She spent two years trying to understand the system (**page 2; lines 15-23**).

1

Appendix C: Evidence of Personal Communication with J. Smith

From: Jonathan Smith <ja.smith@bbk.ac.uk>
Subject: RE: REF UoA4 and Psychology - and an IPA question
Date: 29 June 2018 at 16:21:42 BST
To: "Sarah Riley [scr2]" <scr2@aber.ac.uk>

Hi Sarah

[info deleted]

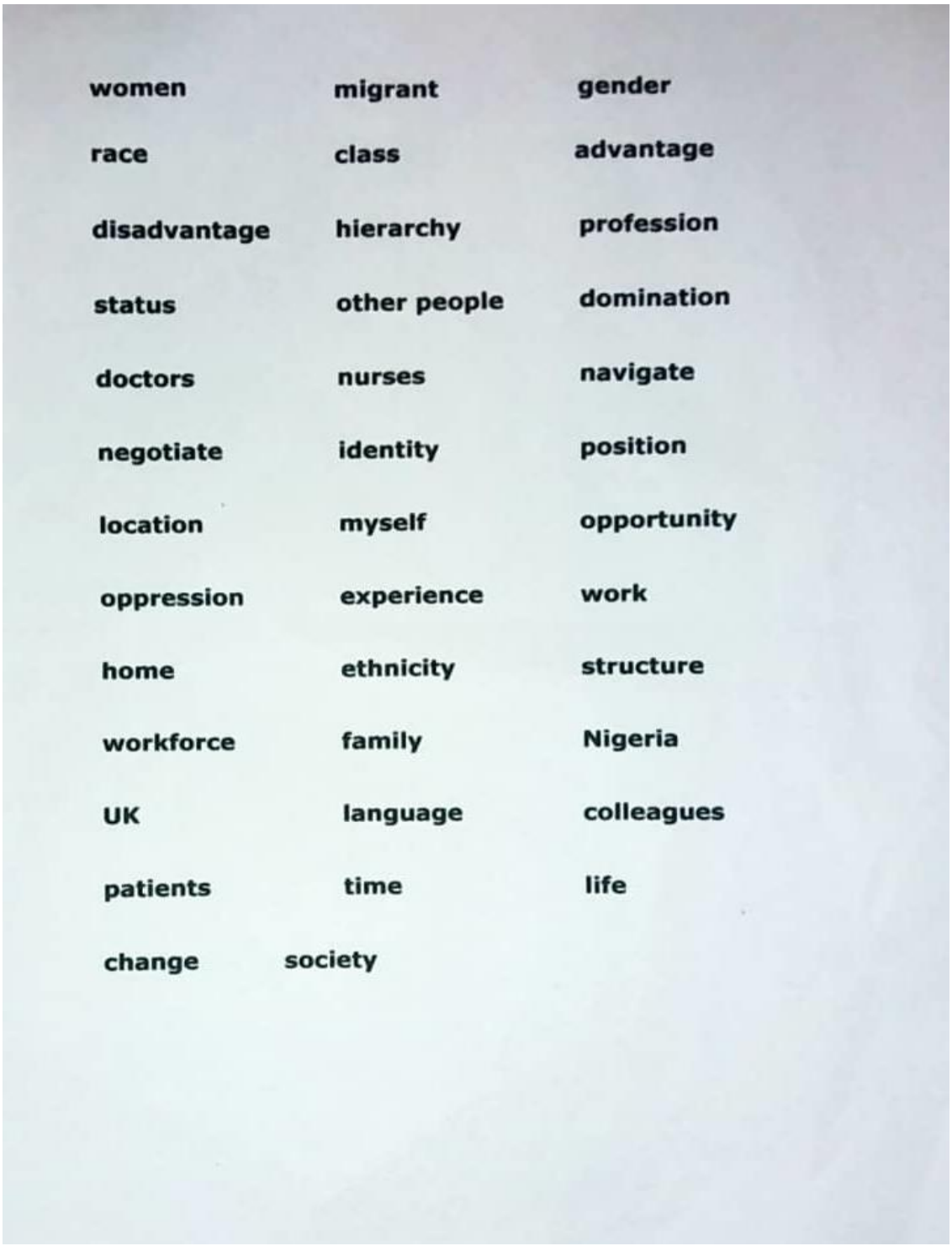
On the IPA question, yes it is fine to do two levels of analysis- first of similarity across the whole group, then at differences between the two groups. Indeed there is more and more of this type of thing happening. At a technical level I might have advised looking at the two groups separately first and then looking across- to be able to signal more clearly the differences and the convergences- but it can be done either way. I realize I don't have much published yet doing these sort of comparisons but I have spent a lot of time recently working on grant apps doing this sort of thing! Attached are three papers which could be of interest.

And yes it is fine to articulate developments/adaptations of the approach- giving the rationale and the process of the adaptation.

Cheers

Jonathan

Appendix D – Card-sort interview sample



Appendix E – Risk Assessment Brief Description of Activity: Interviewing participants in a lone working situation.					Assessor/s: Academic Reviewers	Date 05/08/2014
Hazard *List what could cause harm from this activity, use appendix A to assist in identifying hazards*	Persons at risk *List who might be harmed eg staff, students, visitors*	Risk factor *For each hazard, decide level of risk as if you were to do the activity without controls, see appendix B*			Control measures required *For each hazard. List the measures you will be taking to minimise the risk identified, e.g. appointing competent persons, training received, planning and try-outs, use of personal protective equipment*	Residual Risk *For each hazard now decide the residual risk after the control measures are in place*
		Severity	*Likelihood*	*Risk*		
Situational Hazard Assault by person	Student	Negligible-slight	Unlikely	Low	The person I will be interviewing will be known to someone I know or a member of a Nigerian social group, they will be recommended to me. This reduces the risk of the person being unstable or violent. I will have spoken to the participant to arrange the interview and will only proceed if the person sounds calm and	N/A
Attack by animal	Student	Negligible-slight	Very unlikely	Low		N/A
Transport	Student	N/A	Unlikely	Low		N/A

					professional. I will check that there is network reception on my mobile, before starting off, and I will go with two phones that use different networks to ensure that there is contact with supervisor/family/friend on at least one of the phones. I will not enter the property if I am unable to get a signal nearby so that I can call before and after each interview. I will leave my supervisor/contact with a schedule of interviews (when, where and with whom). I will sit near the door, if possible so I can leave more easily, and make my excuse and leave if I sense any danger (e.g. if they appear agitated). My emergency procedure is to leave the house immediately	

					and call my supervisor/contact. I will find out beforehand (during initial contact with participant) if there are any pets and request that the animals be kept in a separate room from me during the visit on the day (if there is any animal in the participant's house). As I intend getting to participant's by public transport, I will decide means of transport (e.g. bus, train, tube, metro, taxi) and have adequate information on safe routes and timetables. I will also be aware of any social tensions in the area to be visited, and also have a well-planned route, especially if I have to be out after dark, which is unlikely	

					considering the daylight in the summer.	
Signed *NikkyEdeh*		Date: 05/08/2014			Date for review of risk assessment: The review procedure will be reviewed after each interview	

Hazard list – **Use this table to help you identify hazards, you may think of others not on this list, use these to complete the risk assessment form**					
Situational hazards	**Tick**	**Physical / chemical hazards**	**Tick**	**Health hazards**	**Tick**
Assault by person	√	Contact with cold liquid / vapour		Disease causative agent	
Attacked by animal	√	Contact with cold surface		Infection	
Breathing compressed gas		Contact with hot liquid / vapour		Lack of food / water	
Cold environment		Contact with hot surface		Lack of oxygen	
Crush by load		Electric shock		Physical fatigue	
Drowning		Explosive blast		Repetitive action	
Entanglement in moving machinery		Explosive release of stored pressure		Static body posture	
High atmospheric pressure		Fire		Stress	
Hot environment		Hazardous substance		Venom poisoning	
Intimidation		Ionising radiation			
Manual handling		Laser light		**Environmental hazards**	
Object falling, moving or flying		Lightning strike		Litter	
Obstruction / exposed feature		Noise		Nuisance noise / vibration	
Sharp object / material		Non-ionising radiation		Physical damage	
Shot by firearm		Stroboscopic light		Waste substance released into air	

Slippery surface		Vibration		Waste substance released into soil / water	
Trap in moving machinery					
Trip hazard		**Managerial / organisational hazards**			
Vehicle impact / collision		Management factors			
Working at height					

Risk matrix – *use this to determine risk for each hazard i.e. 'how bad and how likely'*	**Likelihood of Harm**				
Severity of Harm	**Remote**	**Very unlikely**	**Unlikely**	**Possible**	**Likely**
Negligible e.g. *small bruise*	**Very low**	**Very low**	**Very low**	**Low**	**Low**
Slight *e.g. small cut, deep bruise*	**Very low**	**Very low**	**Low**	**Low**	**Medium**
Moderate *e.g. deep cut, torn muscle*	**Very low**	**Low**	**Medium**	**Medium**	**High**
Severe *e.g. fracture, loss of consciousness*	**Low**	**Medium**	**High**	**High**	**Extremely high**
Very Severe *e.g. death, permanent disability*	**Low**	**Medium**	**High**	**Extremely high**	**Extremely high**

Appendix F – Example of emerging themes from coding process)

Emerging theme		Initial theme
	Thank you for attending this interview. Erm, we've got a few words here to help us with the interview, so, erm, before we go onto the words. I'd just ask a few questions, if you can tell me a bit about how you came to the UK.	
Highly skilled migrant Economic migrant Overseas training	ANNE: Okay, erm, I came to the UK after I finished my medical degree in Nigeria, because I just felt that, you know, coming here will help me to becoming a better doctor. You know, they have, erm, you know, they [the UK] are more quite advanced, and there were things I was hearing in the university that, erm, I had never seen before, like MRI scans, and some of these their diagnostic equipment. I just felt that coming here will make me be the best doctor that I could possibly be. That's why I came.	Individualistic decision to migrate Optimistic
Aspirations		Career advancement
Highly skilled	Int.: **Alright, erm, what were you doing before you came here?** ANNE: I came in 2006 Int.: **2006, okay. And before then you had qualified in Nigeria** ANNE: Yes, I had finished my medical training and had done my housemanship, which is the first year for foundation for pre-registration doctor, I had done that before I came here.	Economic empowerment
Economic migrant	Int.: **Okay, erm, why did you make the decision to come here? You kind of said that…** ANNE: I just wanted, just felt that apart from the fact that the training here was going to make me a better doctor, I also wanted the opportunity to be able to help my family down in Nigeria. And I felt I could earn more, erm, being in this country.	Feeling optimistic, hopeful
Hope	Int.: **Erm, what did you feel at the time you came in?** ANNE: I was very excited when I came in, really excited, I just couldn't wait to just start off, you know. So I was very optimistic, you know, and excited.	Emphasis on the reality she met using words like 'in fact', 'even'
Long wait to training post Lower skill job opportunity	Int.: **Did it match your expectations?** ANNE: Of course not (laughs) Int.: **Of what you heard back in Nigeria, when you came?** ANNE: In fact, it took me about two years before I even got into a training post. I had to do, erm, go below my standard. I had done my foundation year one in Nigeria, came to this country. When I came to this country I had to start again from where I had stopped, almost	

Appendix G: Initial list of themes (using Anne's interview)

Long wait to training post
Lower skilled job opportunity
Lack of choice of work
Set back during training
Regular relocation due to work opportunities
Stressful relocations
Accent and communication challenge during consultations
Proving one's self in the work environment
Working with colleagues with high expectations
Communication with patients as part of the learning process
Childcare challenges
Prove self as an immigrant
Race as problematic
Challenging being Black at work
Being illegitimate as a black doctor
Proving self as immigrant
Immigrant identity as challenging for partnership position
Prone to have problems at work as an immigrant
Wifely duties as challenging
Motherly responsibilities as challenging
Excellent at work and at home
Regular relocation due to work opportunities
General practice as a less stressful choice
Flexible working as a locum GP
Employing nanny as a coping strategy

Appendix H - Example of clustering of themes using Anne's interview

ANNE

A. PROCESS OF BECOMING

New work identities

Long wait to training post

Lower skilled job opportunity

Lack of choice of work

Set back during training

Regular relocation due to work opportunities

Stressful relocations

Becoming a Nigerian woman in the UK

Wifely duties as challenging

Motherly responsibilities as challenging

Excellent at work and at home

Childcare challenges

Becoming an immigrant

Prove self as an immigrant

B. INEQUALITIES AT WORK

Disadvantaged in the labour market

Race as problematic

Challenging being Black at work

Considered illegitimate as a black doctor

Work as challenging because of routine racism

Accent and communication challenge during consultations

Proving one's self in the work environment

Working with colleagues with high expectations

Communication with patients as part of the learning process

Squeezed out before the top

Proving self as immigrant

Immigrant identity as challenging for partnership position

Prone to have problems at work as an immigrant

C. COPING WITH THREATENED IDENTITIES

NAVIGATING BARRIERS TO GOOD EMPLOYMENT

Conscious positioning (geographic region)

Regular relocation due to work opportunities

SEEKING OUT RESOURCES TO MANAGE THE IMPOSSIBLE

Conscious positioning (specialism)

General practice as a less stressful choice

Flexible work arrangements

Flexible working as a locum GP

Outsourcing domestics

Employing nanny as a coping strategy

Appendix I- Example of individual participant theme table using Anne's interview

Superordinate theme	Subordinate theme	Page/Line no	Indicative quote
Process of becoming	Becoming a Nigerian woman in the UK	8.34	"*I am married to a Nigerian man that expects me to make sure that as I am coming back food is there*"
	Becoming a migrant	13.30	"*sometimes I felt because I was an immigrant*"
	Becoming Black	22.20	"*I might just think is it because I am a black*`"
	Finding new work identities	4.5-6	"*initially I was in obstetrics and gynaecology*"
Inequalities at work	Disadvantaged in the labour market		"*When I came to this country I had to start again from where I had stopped, almost like going below what I should actually have been*"
	Squeezed out before the top	12.24-5	"*They would rather give the partnerships to someone that is like them*"
	Work as challenging because of routine racism	9.33-4	"*if I make a mistake at work, there will be higher litigation for me*"
Coping with threatened identities	Conscious positioning (specialism)	4.12-3	"*I decided that was going to be too much for me. So I then decided, ok, I will do general practice, and then have time*"
	Conscious positioning (geographic region)	5.7-8	"*I had to move from place to place, wherever the job was I had to go*"
	Outsourcing domestics	21.33-4	"*I have a nanny helping me*"

Appendix J – IPA Master Table of Superordinate themes for all the participants

Superordinate themes	Subordinate theme	Participant	Page (Line no.)	Extract
The process of becoming	**Becoming Black in Britain**	Anne	5(26)	"I found out that everybody has a stereotype in their mind as to how they think of someone who is a Black doctor"
		Beverley	3(8-11)	"If you are Black you may feel at a disadvantage, you might feel people are looking down on you"
		Cathryn	9(39-41)	"already as a foreigner, a Black you are already disadvantaged"
		Davina	11(8-9)	"Don't expect much from you because you are Black
		Eileen	4(1-2)	"being from a Black, or minority group, as we are"
		Flora	10(31-32)	"You have all these Black nurses treating all these white… the way they view you is horrible"
		Gail	10(32-33)	"I had to look at the boy and say I'm not a brown lady, I'm a Black woman"
		Helen	2(63-66)	"as a Black African woman you tend to work a bit harder than the rest because you want to prove yourself"
		Jennifer	2(39-40,42)	"In the whole surgery, so amongst the doctors, nurses, admin staff, I am the only Black person here…I sense that there is something different about me"
		Linda	3(39-41)	"That brings me to being a Black person in the UK. Identity, initially when I came in, I did have a bit of issue, with the fact that I felt like I was not accepted"
	Becoming Black in Britain (cont.)	Mary	7(32-34)	"I am Black, and I am a doctor, and hmm. I think that those things kind of affect the way that other people react to me"
		Nina	2(22-23)	"The patient will say oh I don't want you, because you are Black"
		Olivia	6(2-3)	"…visiting a part of Scotland where they don't really see Black people and getting some looks from people"
		Pippa	2(1-2)	"…someone said to me, because you are a woman and you are Black, it will be hard for you to be a surgeon"
		Rose	1(21-24)	"You walk into a ward you are the only Black person; you tend to notice such things. Things that you were not worried about back home started to surface"

		Tracy	2(39-40)	"…as a Black nurse you go through quite a lot of things, even though they say they have equal opportunities"
		Ursula	1(38-39)	"As a Black African and a woman, living in the UK is quite challenging"
		Vicky	6(2-3)	"…Black and ethnic minority seem to have a level they progress to within the nursing field"
		Winnie	3(7-8,10-11)	"…because you are Black, and African… they don't expect us to have high level of education"
		Xara	1(28-29)	"so obviously, there is like a difference between us and white people"
	Becoming a Nigerian woman in the UK	Anne	6 (15-18)	"Then again I am a wife, when I come back from work and I am married to a Nigerian man that expects me to make sure that as I am coming back food is there"
		Flora	2(14-16)	"A woman's role is more of a supportive role in the family, even if you earn more, or your career is way ahead of your partner's"
		Helen	2(13-14)	"Being a woman in the UK is not like a being a woman back home"
		Irene	9(1-2)	"…coming here, you don't have any help…You have to drive yourself, wash your own clothes, look after your own home, do all your chores yourself, compared to, in Nigeria where I didn't have to do those things"
		Karen	8(35-37)	"As a woman, you don't have enough time for your children, you don't have enough time to be a good wife to your husband"
		Nina	1(35-37); 2(1-2)	"As a woman, I have got two children, how do I say, it is actually not easy being a woman in this country and not having your family… women have to do everything and men just sit down… because they are Africa men the women have to do it"
		Sharon	3(40-42)	"Back home you can be a housewife and your husband goes to make the money… but here you have to do everything"
	Becoming a migrant	Anne	9(31-32)	"sometimes I felt because I was an immigrant"

		Eileen	11(26-27)	"I think people are beginning to embrace immigrants"
		Flora	19(41-43)	"Yes, as a migrant I feel limited, I feel I have to prove myself"
		Gail	2(22-24)	"The thing is, as a migrant, somehow you are not getting support. You are more or less a second class citizen in this country"
		Helen	2(22-24)	"As a migrant, as an African, you don't have the British accent… your colleagues pretend or they feel they don't understand what you are saying"
		Irene	2(22-23)	"I'm able to connect with other migrants like myself who are facing similar challenges"
		Jennifer	5(13-14)	"if you are a migrant, you have to prove yourself extra"
		Karen	3(31-34)	"being a migrant at work, sometimes you have the patients, you get the awkward patients, and they just tell you I don't want to see you, a foreign doctor"
	Becoming a migrant (cont.)	Mary	2(22-25)	"I think one of the things that stood out for me as a migrant, as soon as people saw you they want to know where you are from"
		Olivia	8(33-34)	"So, in terms of being an immigrant in the UK, that is a disadvantage"
		Pippa	2(13-15)	"When I first came to this country, one of the things they said was it might be more difficult getting jobs in London as an immigrant"
		Quincy	2(20-21)	"one felt disadvantaged by being a female, by being a migrant"
		Rose	2(18-19)	"You are always seen as a migrant. Everybody asks you where you are from originally"
		Sharon	2(10-12)	"…with most migrants that have come into the UK, where you find you come here and you have to adjust"
		Tracy	3(35-37)	"I was just trying to know more about the work, and as a migrant in the UK how you experienced work in the UK"
		Winnie	1(35-37)	"Okay, as a migrant doctor in the UK, first of all, you need to prove yourself, and even if you prove yourself, especially at the beginning"
	New work identities	Anne	1(44-49)	"I came into this country and I wasn't sure what I wanted to do. I started off

				doing obstetrics and gynaecology… so I better do general practice"
		Beverley	22(8-11)	"When I came here [UK] there were a lot of disappointments, I couldn't get work immediately… so I had to have a research post, unpaid research post"
		Cathryn	8(1-2)	"I studied Psychology before I came… I went into care … I was a catalogue distributor, e mm, I went from door to door, which I never imagined"
		Eileen	13(39-42)	"I was just not advised properly, as I thought going into medicine maybe a bit difficult, I had just turned twenty one, so I decided, ah, I wanted nursing"
		Flora	2(1-5)	"It wasn't like, oh I have always wanted to be a nurse, kind of thing, but when I got here and subsequently I was advised, it was either you do nursing or do the training and become a teacher"
		Gail	7(29)	"I worked in a nursing home"
		Helen	3(6-9,14)	"I did banking for a year, I was in the marketing area, then I came here. I never thought of being a nurse but I couldn't afford to go to the University … so that is what made me go into nursing"
		Irene	1(9-12)	"I came as a student...after one year of studying at Master's degree level, I decided to go into the health care profession. So I started from the beginning. Trained as a nurse, then I went on and trained as a midwife"
		Jennifer	4(7-9)	"My first job in the UK even though I was a doctor was to deliver leaflets into people's houses, it was horrible"
		Linda	1(38-41)	"I had always wanted to be a teacher, so when I got married, I was tossing around teaching and nursing, well not tossing around, and I had done a care job as a student… I did try to work in a bank… Then I had the interview for the nursing come first, and I got through"
	New work identities (cont.)	Mary	10(12-15)	"…opportunity created itself for psychiatry, and I also thought it would give me a better work-life balance for when I wanted to start a family"
		Nina	1(17-18	"Actually when I came to the UK, I struggled, I started with healthcare

				assistant, before I could get an adaptation…I am now a staff nurse"
		Pippa	3(7-8)	"I was going to be a surgeon, but the hours were so difficult with home so I chose to be a GP"
		Quincy	2(2,7-9)	"the first was Obstetrics and Gynaecology… I made a decision to switch to general practice, which was primarily to help me meet my family obligations"
		Rose	9(9-10)	"Paediatrics is not a field that's white-dominated, so not many white want to do it, so it also helped, you know for me"
		Sharon	1(8-9,13-14)	"I originally came as a student, to do my Masters in business administration, there weren't jobs in that… so that made me change my profession and I went to train as a nurse in the University"
		Tracy	1(10-11,18-19)	"I intended to study and then go back home… I went to do a two-year secretarial course, then worked as a secretary for about two to three years… I just wanted some stability, so I decided to go into nursing in 2003"
		Ursula	2(3-6)	"if you like have a degree back home and things like that … you kind of have to do some courses, get used to the system, how it works and that will set you back a little bit"
		Vicky	1(27-28)	"My initial field of profession was food science and technology, then my Masters in business admin…I looked for work in the banking sector, within the food and hospitality sector, I looked for work within the customer service sector, and it wasn't just forthcoming… so I just took on health care worker"
		Winnie	1(6);2(22-24)	"I am a GP…I initially started training in obstetrics and gynaecology, but I left… it hindered my career progression"
Inequalities at work	**Disadvantaged in the labour market**	Anne	1(41-43,49)	"I think it was because I wasn't in the system. If I was in the system, and gone to medical school here… it took me a long time"
		Beverley	2(16-18)	"the bias against women also, some employers may feel a woman will get pregnant and leave with maternity pay"

		Cathryn	9(39-41)	"Already as a foreigner, a Black you are already disadvantaged… it makes it very difficult for you to get jobs"
		Flora	17(33-36)	"if a Black (sister or brother) applies for the same job, you [the recruiter] have a duty to make sure you [the recruiter] support the Caucasian to get it"
		Gail	13(29-32,33-36)	"I have the toxic trio…these are the things that I feel are stopping me from getting a good job… I did my nursing back home which is in Africa (a black man's land), that is one; I am a black woman, that is two; and the third one, my nursing was a diploma"
		Jennifer	10(36-40)	"Women are put in a place, because of the fear that these women are going to go on maternity leave… the first person that they would employ would be a middle-aged white man"
	Disadvantaged in the labour market (cont.)	Mary	15(22-26)	"With the European countries … even when they can't speak English, they do not have to do the sort of rigorous exams that I had to go through"
		Quincy	2(35-37)	"It was not easy to get on the training hierarchy in the hospital position…it was designed in my opinion to be highly discriminatory"
		Sharon	1(10)	"…there were jobs but I couldn't get one as a migrant"
		Vicky	4(5-7)	"…menial kind of work was what was available, or people were willing to give you interviews, and it was really disheartening"
		Winnie	1(35-37)	"As a migrant doctor in the UK … especially at the beginning, it is actually very difficult to get into the system"
	A squeeze before the top	Anne	8(41-44)	"Sometimes it is difficult as an immigrant to get partnerships… they would rather give the partnerships to someone that is like them"
		Beverley	9(29-31)	"When you finish your training to become a consultant…the appointments are usually for the people based here, the natives of this place"
		Eileen	3(24-26,30-32)	"I was going up for a promotion … I really felt at the time it was basically due to my

				race, I wasn't given the same opportunity"
		Flora	14(1-4,8-10)	"…everybody comes in at the base, then you are going up, it narrows and you tend to see less Black women… as it squeezes up to the top, it squeezes out the Black women"
		Helen	9(27-30)	"…where I work now you don't see many Black people up there, like you can see Black band 6 nurses but it is rare to see a Black band 7 nurse"
		Irene	4(22-24)	"It's even more challenging to try to stay at the top there, than to get there"
		Jennifer	8(11-13)	"Many of these people they strive and they finish up and they are worried about getting a consultant post"
	A squeeze before the top (cont.)	Mary	11(2-4)	"…as a Black female doctor, and I think the higher you go the harder it becomes"
		Nina	8(30-33)	"I have been here ten years now no move to band 6, and I have seen somebody just qualified maybe three years ago, got the position of band 6"
		Quincy	2(41-43)	"…to get beyond that to the higher post, the Senior Registrar and the consultant post is virtually impossible as a migrant and as a female"
		Rose	6(34-36)	"Very few senior people are Blacks; they may be mainly Asian or white, rarely Black"
		Sharon	3(15-17)	"If there are like promotional courses going on… they promote the English ones"
		Vicky	6(17-21)	"…if you follow them through ten years after graduation, and you check the black or ethnic minority nurse, you'd see that where they've gotten to is maybe band 7 or 8, while the Caucasians have gotten to the tip of their career just within the first 10 years of their career"
		Winnie	6(2-3)	"You find that the higher you go the less Black and ethnic minority group that you see in those high positions"
		Xara	8(15-16)	"…as you go higher up especially the consultant positions, you will find a lot less female consultants, a lot less and certainly very few black women"

		Cathryn	16(41-45)	"…it is rare to find blacks even at band 6 level, people still believe that we are not good enough for the job".
	Work as challenging because of routine racism	Anne	6(47-49)	"Because I am an immigrant, it is more likely that if I make a mistake at work, there will be higher litigation for me"
		Beverley	4(13-17)	"it is a disadvantage, it's just that idea of one coming from Africa, I am Black, you know, they think I don't know anything"
		Flora	19(39-42)	"it is only when you are a migrant that they have to phone the home office to ascertain that your indefinite leave is a true indefinite leave"
		Gail	23(3-6)	"If you're fortunate, it's to find someone who sees you beyond your colour"
		Irene	5(19-20,24-25)	"their expectations are different based on your colour, on your race… I say, I'm the midwifery manager or I'm the nurse manager here, they don't understand that"
		Jennifer	8(19-21)	"I have to prove myself, that all eyes are on me, from the patients to my colleagues"
		Karen	2(14-16)	"Being a Black woman, coming from a different country, and the way they litigate doctors, if you make any mistake you are out"
	Work as challenging because of routine racism (cont.)	Mary	5(20-22)	"…people say I don't mean any offence but I don't think you would have trained here being a black woman, and I mean, I think that is very, it is actually very offensive"
		Nina	4(18-21)	"The police comes to my ward asking me my status instead of asking for the name of the patient that absconded"
		Quincy	3(6-9)	"I have talked about working harder to avoid litigations because any litigation against you tends to be a bit more analysed than your indigenous counterpart"
		Rose	2(11-12)	"You are Black and there is a whole lot of difference...you tell people things they don't believe you"
		Sharon	2(37-38)	"…this chap rang the bell, I responded to the call and he just looked at me and said please get me a British nurse"

		Tracy	1(39-40)	"…it's had its up and downs, as a black nurse you go through quite a lot of things, even though they say they have equal opportunities"
		Winnie	3(36-38)	"I have had people who have behaved towards me (for want of a better word) in a way I haven't expected but because of my race… People treated me differently because I am black"
Coping with threatened identities	**Navigating barriers to good employment**	Anne	1(45-49)	"I started off doing obstetrics and gynaecology, then along the way I found out this is going to be so stressful for me and my family, so I better do general practice"
		Beverley	7(5-7)	"I stayed on because there were more opportunities here in Scotland than in England… I have never lacked a job"
		Cathryn	7(4045)	"I studied psychology before I came, and my dream was to be a clinical psychologist, but unfortunately when I came in here, I looked for jobs everywhere, and there was no experience for me so it was nursing for me"
		Gail	13(36-39)	"Before I start putting myself through hell, let me improve my chances, so I went back to the University… Now I have my degree"
		Irene	1(9-12)	"I started from the beginning, trained as a nurse, then I went on and trained as a midwife… there was still need for migrants in the field of health care"
		Jennifer	8(9-11)	"…you are sure that as a general practitioner, when you finish your training you will be accepted somewhere for you to work"
	Navigating barriers to good employment (cont.)	Mary	8(1-2)	"Initially I was ready to go to the Outer Hebrides (Scotland), that was where I got the job, my first job"
		Nina	1(16-19)	"when I came to the UK, I struggled, I started with healthcare assistant, before I could get an adaptation… I am now a staff nurse anyway"
		Pippa	3(6-8)	"initially I thought I was going to be a surgeon, but the hours were so difficult with home so I chose to be a GP"

		Quincy	2(2-3,7-9)	"the first was obstetrics and gynaecology… so I made a decision to switch to general practice, which was primarily to help me meet my family obligations"
		Rose	9(8-10)	"Paediatrics is not a field that's white-dominated… so it also helped, you know for me"
		Sharon	7(17-20)	"I went into nursing because I couldn't get a job in the other field where I had wanted to aspire well in, so when I went into nursing I didn't look for the job, the job came to me"
		Tracy	1(15-19)	"I did my HND in business and finance, and then I worked for a few other local authorities …I decided to go back into university to do nursing as it was just too much reshuffling and people were just been laid off and I just wanted some stability"
		Vicky	1(5,29,35-36)	"I was looking for work… it was like hitting walls. A family friend then said to me, have I tried looking into nursing… I am in the mental health field of nursing"
		Winnie	2(28-30);1(6)	"I found it difficult, to actually do the job, that was obstetrics, and then be a mother as well. That is why I decided to make the transition…I am a GP"
	Seeking out resources for managing the impossible	Anne	14(30)	"I am a locum GP; I work anywhere…that is what I decided to do because of the family"
		Beverley	4(12-14)	"…that my husband was really supportive, really, really, supportive. Because I came first, he was still back home with our kids"
		Cathryn	19(19-22)	"On a typical day I prepare myself and my children and take them to the childminder before going to work "
		Eileen	13(12-13);14(16-17)	"Once I had kids my priorities did change... getting flexible working hours"
		Helen	6(4-5)	"It wasn't easy because I had to leave her and her sister with the child minder… because I do a 12 hour shift from 6.30 to 7.30"

		Irene	7(2-3)	"It was quite a challenge, but fortunately for me, I had extended family when I was studying"
		Karen	5(22-24); 9(4-6)	"I have a very good and supportive husband, without which I don't think I would be where I am today… the things a woman should do, which I have not been able to do, he's having to do them"
		Nina	2(2-3)	"Coming back from work, doing many things, I have a husband, he helps"
		Quincy	4(12-14)	"I had to rely on private education for the children because I could not give enough time in the home to bring them up"
		Tracy	2(11-13)	"I went into agency work because my son was still quite young at the time… I was my boss, I could choose when I wanted to work"
		Ursula	8(8-11)	"I like the flexibility that I work for myself…like a single parent…and do your agency work, whereby you work when it is ok for you in your circumstances"
		Xara	4(24-26)	"I think my family is important, mainly my kids are important. I think it's important to spend time with them., so I work part time. So I insist on working only 3days a week not anymore"
	Emotional strength	Anne	4(18-19)	"I've been very lucky, I've had good colleagues that have been supportive"
		Beverley	8(27-28)	"I have been able to get to where I am because of my family. I believe family is very important"
		Cathryn	11(5-8)	"90% of the things I do is dependent on my faith. It stands out for me, even in my workplace, that has been my strength, and it makes difficult and challenging situations very easy to go through it"
		Flora	6(25-26)	"I had my family so I didn't feel too isolated or alone"
		Helen	6(35-37	"It can be lonely sometimes like my family is not here but my husband's family is here, so it makes it a bit easy"
		Irene	4(10-12)	"there's also the element of your faith, your belief, your spirituality; it's all these things, you know, that help to move you forward"
		Jennifer	1(29-30)	"I am a Christian, and I really depend on God"

		Karen	5(23-24)	"I have a very good and supportive husband, without which I don't think I would be where I am today"
		Linda	4(5-7)	"why I went into nursing was that there were a couple of other Black people in there that made me feel a bit more comfortable"
	Emotional strength (cont.)	Mary	11(1-3)	"family... made it possible for me, with living in a foreign country" "Being a Christian, it kind of helps you modify your reaction, or your understanding of it, and your ability to cope with it"
		Rose	13(34-35)	"from being a child you are always told the person that came first does he have two heads"
		Sharon	1(35-38)	"Well by God's grace I scaled through and we Nigerians, we are very, very strong, hustlers, so we kind of survive in any condition we find ourselves in"
		Vicky	2(26-27)	"Family was really an essential part of my life"

Appendix K: Participant Information Sheet

Study Information

I am a PhD student in the Psychology department at Aberystwyth University. You are being invited to take part in a research study which will involve one-to-one, individual interviews with 30 Nigerian healthcare professionals about the role of professional status in mediating the experiences of female migrant healthcare workers in relation to their gender/sex, ethnicity, and migrant status.

What is the purpose of the study?

I am interested in your experience as a female migrant healthcare professional and the implications of professional status for female migrants from Nigeria working in the British healthcare sector. By so doing this study seeks to gain a better understanding of the ways in which professional status mediates how these women negotiate and experience their work and home lives in relation to their sex/gender, ethnicity, and migrant status. Is the impact more of an advantage or disadvantage in relation to the multiple identities? This study is not designed to be of benefit to you directly, but it is hoped that the results might help us understand if the experiences of these women are similar or different, and whether we can identify strategies and solutions to bring about positive social change and justice, if needed.

What would be involved for you?

As an individual who has moved to the UK within at least ten years, you have been asked to take part in an interview with me about your feelings, opinions, and experiences of how the professional status of Nigerian female migrants working in the health care sector navigate your multiple identities at work and at home. You will not have to talk directly about any topic that makes you uncomfortable. There will be an activity in which you choose words that relate to the topic in your experience. You will therefore be able to choose the subject areas you discuss, and decide how much or little you wish to say. The interviewer might ask further questions about a topic you raise, but you will always be able to say if you do not wish to answer or discuss a topic further. The interview will last between 30 and 60 minutes, and will be tape recorded throughout, though you will be able to stop the recording at any time, or ask for all or parts of the recording to be deleted or not included in the study.

Are there any risks to participating?

This study has been designed according to British Psychological Society guidelines and it is hoped that taking part in the study will be an interesting and enjoyable experience.

However, it is possible that talking about migratory experience could be seen as an invasion of one's privacy or distressing for some participants. If that happens, the recording will be stopped, and the interview will only be resumed if you wish, and if you and interviewer agree that it is appropriate. After the interview, if you have any concerns, or the interview has raised issues which you would like to discuss or explore further, a list of resources will be given to you afterwards.

Do I have to take part?

No, taking part in the study is entirely voluntary. You can withdraw from the study at any time before, during, or after the interview. If you wish to see a copy of your transcript, it will be made available to you, and if you decide at any point up to the end of March 2015 that you would like your interview data not to be used, it can be withdrawn from the data set and not used in the final research.

Will my responses be kept confidential?

Your interview will be anonymous, and your name will not appear anywhere on the transcription. I will type out the interview, and it will be stored on a password protected computer, and in a locked filing cabinet. It is this transcript which will be used to look at how participants make meaning of their experiences in navigating their professional status in relation to the multiple identities. Again, the typescript will also be anonymous, and any identifying details that may appear in the interview (e.g. names, places) will be deleted. When this is completed, I will contact you and offer you the opportunity to read your interview transcript. If there are inaccuracies, I will correct them, and if you would like any part of your interview not to be used, I will delete those sections from the transcript.

The analysis will be written up, and may contain direct quotes from what you have said. However, if this happens, it will still always be anonymous.

The written analysis will be presented as part of a PhD thesis, and may also be presented at conferences, or appear in a journal article. In all of these cases, no names of any participants will ever be used.

Your interview will only be discussed with other researchers, and in any discussions with other researchers, your identity will be similarly protected. I will not disclose the identity of any participants.

What if I have any concerns?

If you have any concerns about the interview or your confidentiality, you are always welcome to contact me (nke@aber.ac.uk) or by phone: 01970622796.

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Appendix L: Participant Consent Form

Participant Consent Form

Title of project: The role of professional status in navigating through multiple identities of Nigerian female migrant health care workers

Name of researcher: Nkechinyelu Edeh

Participant Identification Number for this study: _____

Please put your initials in the following boxes to indicate that you agree with the statements below and give your consent to participate in the study.

1) I confirm that I have read and understood the information sheet for this study. I have been given the opportunity to consider the information and have had any questions answered satisfactorily. ☐

2) I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

3) I understand the steps that will be taken to keep my information anonymous and the limitations to confidentiality have been explained. ☐

4) I agree to take part in the above study. ☐

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of researcher	Date	Signature